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Child Survival Program

Kibilizi Health District
Butare Province, Rwanda

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Midterm Evaluation

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Acronyms

BCC	Behavior Change Communication
CDK	Clean Delivery Kit
DMO	District Medical Officer
FrR	Francs Rwandais – 570FrR = US$1
HIS	Health Information System
ITNs	Insecticide Treated Nets
LQAS	Lot Quality Assurance Survey
MNH	Maternal Neonatal Health
MOH	Ministry of Health
Mutuelle	Rwandan pre-payment scheme for health services
PMTCT	Prevention of Maternal to Child Transmission
TBA	Traditional Birth Attendants
VCT	Voluntary Counseling and Testing (for HIV)

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A. Executive Summary

The Kibilizi Health District Child Survival Program seeks to decrease the mortality and morbidity of mothers and children under five through interventions in HIV/AIDS, malaria, maternal newborn health (MNH), and nutrition. It is working in partnership with the Kibilizi District Ministry of health (MOH) at the District and health center levels, while it has established associations of community volunteers (animators, traditional birth attendants (TBAs), traditional healers, and persons living with AIDS) at the community level. Members fo these associations are then responsible for increasing access to basic services (safe delivery, post partum care, standard malaria treatment, condom distribution, and growth monitoring) as well as for providing preventive health education. The project has also supported the establishment of health and mutuelle committees for each health center. A project "activist" has been assigned to each health center in order to catalyze and support these activities.

The project supported the establishment of two voluntary counseling and testing (VCT) sites, one Prevention of Maternal to Child Transmission (PMTCT) site, two associations for persons living with AIDS (PLWAs) and twelve ant-AIDS clubs. Over two thousand five hundred subsidized insecticide treated mosquito nets (ITNs) have been distributed through pre-natal care clinics throughout the project area, and providers were trained in a revised malaria case management protocol. The project formed associations in all of the health zones for health animators and TBAs, and several associations for traditional healers were also formed. Finally, three growth monitoring sites have been established and associated staff and district partners were trained in the Hearth positive deviance model for malnutrition intervention, although this intervention has not yet been implemented.

According to both the monitoring system and the recent Lot Quality Assurance Survey (LQAS), the project seems to be making good progress towards its objectives. They have made particular progress in the use of impregnated mosquito nets and HIV testing. Institutional deliveries have also increased, but it is not clear whether this can be attributed to project activities since the MNH interventions have so far been limited.

Implementation has suffered due to a lack of clear focus on essential messages, working through too many community partners, and, in the case of the MNH interventions, lack of a comprehensive strategy to maximize impact. It has also suffered from an extremely challenging relationship with the District Medical Officer during the first two years of the project, although staff have now changed and the relationship is improving at both health center and district levels. High project and district staff turnover, and the tendency to pull field staff into administrative tasks also contributed to partnership difficulties.

The training efforts have focused on training activists and representative government partners in technical content for the four project intervention areas. In the HIV/AIDS and malaria interventions, where training has been more integrated with a comprehensive program approach, there seems to have been more impact. In areas where training was

less focused and not integrated with other activities, such as the teacher training, general nutrition training, or TBA training, the impact is more questionable.

The project framework for sustainability is now focusing on the behaviors at the household level, and the community and health service structures that need to be in place to support those behaviors. With the MOH as the primary partner, it is likely that the essential services will continue after the end of the project. IN addition, the project has been actively involved with a national Child Survival working group which serves as a forum for sharing ideas and resources.

At the community level, the associations of volunteers may offer a forum for continued interaction and even income generation to support community activities. The evaluation recommended experimenting with using the health committees to provide "per diem" (snack money) for health center staff as a way to encourage them to take responsibility for supporting community activities. If successful, this would enhance the likelihood that the community activities would continue.

All of the recommendations were developed as part of the participatory evaluation process. A consolidated list of recommendations is attached in Annex 1. Priority ones include:

- Identify and integrate the key behaviors for the four intervention areas and elaborate/implement a behavior changes strategy in partnership with the district.
    - Identify a package of key messages to be delivered consistently throughout the project
    - Consider limiting project effort and activities in the mobilization of traditional healers, teachers, and anti-AIDS clubs since this tends to dilute project focus.
    - Identify and prioritize the extension of successful pilot activities such as growth monitoring/Hearth, VCT, PMTCT, and TBA training.
- Decrease the administrative responsibilities of the activists so they can really spend their time in the field. Assure regular supervision and follow up of field activities at both the community and health center/activist level and move a core child survival team to Kibilizi to facilitate this.
- Involve the full health center team in support of community activities and have the activist orient them during the remainder of the project. Where feasible, provide a small budget to the health committee to support health center staff's field visits as a means to increase their commitment to community activities.
- Explore MAP and/or PEPFAR funding for PLWA associations and existing anti-AIDS clubs as a way to provide additional financial support and income generating activities. Consider transfer of school-based activities and anti-AIDS clubs to other programs such as education or the integrated AIDS program.
- Revise Safe Motherhood Strategy for the District based on international best practices. Update the TBA curriculum to emphasize essential messages and behaviors according to international standards. Orient health center providers to the essential elements of pre-natal, post partum, and newborn care.

B. Project Objectives / Strategies / Accomplishments

The project's broad goal is to *contribute to a sustainable reduction in maternal and child mortality and morbidity, and increased life expectancy for 75,000 women of reproductive age and children under-five years in Kibilizi district, Butare Province*.

Based on baseline studies and local epidemiology, the project is focusing on four intervention areas: HIV/AIDS, malaria, maternal newborn health, and nutrition. Review during the midterm evaluation indicated that these interventions were appropriately selected, and people were satisfied with the priorities they represent.

Significant project objectives with their baseline and estimated midterm coverages include:

Indicator	Baseline	Midterm	Comments
Increase for 10% to 20% the number of adults who are tested for HIV	10%	Men – 26%, women 19% (LQAS '04)	HIS numbers for 2003 indicate 2% and 4% respectively, but do not account for people tested outside the district
At least 50% of women in prenatal care are tested and part of PMTCT	0%	90 – 98% in Kansi Health Center (Kansi register)	Kansi is the only center with PMTCT services. Women do come from other zones to participate.
Increase to 10% the number of children age 0-23 months who slept under a mosquito net the previous night	0.9%	Children 0-11 months - 34% (LQAS '04)	Same in LQAS and HIS. Children 0-11 months measured, since mosquito nets have only been available for a year.
Proportion of women with children under 2 who had at least 2 doses of TT during their last pregnancy	23.8%	68% (2+ TT) 90% had ANC 1 while 48% had ANC3 (LQAS '04)	Project has not yet had significant interventions in MNH beyond training TBAs in 3 health zones
% of institutional deliveries	15%	28% (LQAS '04)	HIS 2003 indicates 17% - but doesn't count deliveries outside the district (e.g. the hospital)
Reduce the number of children 0-23 months less than 2 SD below normal.	58.7%	38%	(Community GM in Gikore indicates 88% malnourished). Variance may be due to high participation by mothers with malnourished children seeking food support following departure of WFP and/or quality of recording.

A more detailed summary of quantitative results, including those for intermediate indicators, is included in Annex 9. The complete LQAS report is included in Annex 10.

Project strategies for addressing these objectives involved capacity building for high quality and sustainable health services, and empowering communities for better health through utilization of locally available resources. The project assigned a health activist to each health center take the lead on community level activities for improved access and prevention. These included the establishment of associations for different community

health volunteers such as TBAs, health animators, and traditional healers. These associations provide a forum that encourages these health workers to provide health education, mobilization, and a few basic services at the community level. Associations were also established for PLWAs. Services include distribution of condoms, clean deliveries with recognition of danger signs for referral, community growth monitoring with a plan for establishing positive deviance nutrition groups for moderately malnourished children, and planned community-based treatment for uncomplicated malaria.

At health center level the activists strengthen the health center support for community activities and support project training for improving health center case management capacity in the intervention areas. Specifically, this has included training in new case management protocols for malaria, training in counseling for HIV testing, and plans for strengthening case management for malnourished children. Strengthening
District support structures such as supervision and planning are also part of the strategy.

Specific project accomplishments include:

- Formation of associations and monthly meetings for 166 health animators and 267 TBAs in 7 health centers and 186 traditional healers in 4 health centers
- General training of community volunteers in HIV/AIDS, nutrition, and malaria
- Training of trainers for mutuelle management and established mutuelle committees for each health center
- Completion of the baseline survey, participatory rural appraisal, and special studies in gender and bednet utilization
- Human resources management training for health center and district managers (9)
- Developing partnership with district health team through joint planning, problem solving, and resource sharing.
- Rapid response to a meningitis outbreak during the first year
- Establishment of 2 PLWA groups and 12 anti-AIDS clubs including assistance for income generating activities
- Establishment of 2 VCT sites and 1 PMTCT site with good levels of utilization
- Distribution of 2416 subsidized insecticide treated mosquito nets through pre-natal care in 7 health centers reaching
- Advocated pilot of community treatment of simple malaria with National Malaria Control Program
- 3 community growth monitoring sites established, with staff trained in the Hearth positive deviance intervention
- Malaria training for case management using the revised national guidelines
- Updated training curriculum and 45 TBAs trained in safe deliveries

C. Technical Approaches

C.1. HIV/AIDS

The project took a multi-valent approach to address the problem of HIV/AIDS including establishment two VCT and one PMTCT centers, the establishment of two PLWA associations, effective and appreciated condom distribution at the community level in all seven health center zones, establishment of Anti-AIDS clubs, and teacher training in HIV/AIDS. There is also an effort to expand health center support for PLWAs, including proposals for home visits, but this will be difficult if the VCT counselor is the only person who knows a patient's sero-status.

There seems to be significant demand for counseling and testing services. The survey numbers are inconsistent with those from the information system, probably due to people who are tested outside the project area. However, they indicate that testing has increased from 10% at baseline to 19% for women and 26% for men at midterm. In addition, 90-98% of women in pre-natal care where PMTCT services were available (Kansi Health Center), were also accepting testing and some women were coming from outside the zone because of the PMTCT services. The ability to integrate testing with the option of Nevirapine for pregnant women and babies, and the availability of the PLWA associations increase the incentive to be tested. The testing program is strengthened by extensive coordination with the national testing program including training, quality control of testing, and the joint project/national commitment to assuring the continuous availability of reagents.

However, access and quality assurance for the testing is limited by a problem with reliable transport to Kigali for the quality control samples, and dependence on project staff for transporting samples from outlying zones to the testing centers. Even though the price for testing is only 300 FrR (about $.50), this is also cited as a barrier. Finally, spouses tend not to be tested in the PMTCT program. This leads to a problem with making sure newborns get the needed Nevirapine dose when deliveries are occurring at home. Women are given their dose in advance of delivery, but the newborn dose is in drops and requires the baby to come to the health center. With husbands not knowing their wives are HIV positive, it is difficult for women to explain why they should bring a healthy baby to the health center so soon after birth. In all cases, follow up, including the possibility of home visits, would be enhanced if permission to share a patient's sero-status with other health service providers were obtained during the initial post-testing counseling.

The PLWA associations are a particularly strong project intervention. (see highlight section at the end of the report) They are personally transforming for their participants, offering a sense of purpose and self-worth to people who are otherwise ostracized from society. They encourage participants to provide testimonials and do community education on AIDS and AIDS prevention, which has the added benefit of decreasing the stigma associated with being sero-positive. Finally, they provide a forum for establishing income generating activities targeting some of the poorest people in society. In one case, the

income generated was used to pay for treatment of opportunistic infections for the members. Unfortunately, with the growth in membership, the expense for medicines was exceeding the income generated.

The Anti-AIDS clubs and teacher trainings were the weakest part of this strategy. Most of the training was information – transfer, follow-up support to reinforce messages and activities was sporadic, and little thought was given to how these efforts integrated with education programs. In order to be effective, these activities need more thought and support than has been given to date. At this point, while these are important activities for AIDS prevention, they may be unnecessarily diluting the focus needed for this project to achieve its primary goals and objectives. Consideration should be given to raising additional funds for their support and/or transferring these activities to other programs such as education or the cross-cutting AIDS efforts.

Recommendations

- *Assure timely transfer of VCT quality control samples to Kigali on a fixed schedule and negotiate with TRAC to assure timely return according to schedule*
- *Expand and support the PLWA activities (including home visits to promote participation, request permission to notify other staff of results during post test counseling,)*
- *Explore MAP and/or PEPFAR funding for PLWA associations and existing anti-AIDS clubs as a way to provide additional financial support and income generating activities in order to have the necessary resources to effectively integrate AIDS activities with those of child survival.*

C.2. Malaria

This is currently one of the strongest project interventions. The strategy is comprehensive and well integrated, addressing improved case management, moving towards community-based treatment, assuring availability of insecticide-treated bednets (ITNs) particularly targeting the most vulnerable population of pregnant women and children under two, and local awareness raising. The project has advocated at the national level, particularly for community-based malaria treatment, subsidy for treated mosquito nets, and prophylactic treatment for pregnant women. Significant progress has been made on the first two while a pregnancy treatment policy is still pending.

The project provided training to service providers in all seven health centers to update their case management skills according to recently developed national protocols. In addition, it made subsidized ITNs available through pre-natal care consultations which are ultimately protecting both pregnant women and newborns. A follow-up utilization study indicated that this was indeed the case, and that the nets were not being resold despite the price subsidy. The midterm LQAS survey indicated that the percentage of mothers of children under one who slept under a net the night before the survey went from 0.9% to 34%. The increased availability of the subsidized nets has also led to increasing demand, with people expressing willingness to pay the full price. There is not yet any distribution system in place to increase access to ITNs beyond the pre-natal clinics.

The availability of community treatment has been moving slowly despite the advocacy with the national malaria control program. There is agreement on the pilot sites which include the project District, and the project will be implementing the strategy shortly. However, a training module and treatment protocol has been developed with WHO technical support. Training is expected to start prior to arrival of pre-packaged drugs in June 2004.

Recommendations

- Expand the availability of ITNs to the general population even if the price isn't subsidized. This will be facilitated shortly with the importation by government of permanently treated nets at more reasonable prices. Under-five children and PLWAs should be particularly targeted.

C.3. Maternal Newborn Health

Up to now, the MNH strategy has included development of training materials and training of the first three groups of TBAs, development of a clean delivery kit (CDK), and formation of TBAs into associations with regular meetings which provide a forum for ongoing education and follow-up. TBAs are still the front-line maternity care providers such that training them in danger signs, prompt referral, birth preparation, clean delivery, and essential newborn care is an appropriate strategy. The lack of available gloves in villages makes the CDK an important strategy for protecting TBAs as well as facilitating clean deliveries.

Meetings with the TBA associations showed a high level of enthusiasm for participation. Even untrained TBAs were learning significant information from the monthly meetings and, in areas where the TBAs had been trained, from the trained TBAs. While inconclusive, there may also be increased referral of deliveries in areas where TBAs have been trained. Finally, even with limited project intervention, there is very high (up to 90%) attendance for 1 pre-natal visit. While there is significant drop out (48% have 3 pre-natal visits), the opportunity to reach nearly all pregnant women at least once with essential messages and services is not to be underestimated.

In spite of these activities, the coherence and comprehensiveness of this strategy is still weak. The essential messages and behaviors have not been clarified, and there has not been an integrated effort to integrate interventions at the household, community, and health center levels.

At the household level, the LQAS survey identified generally low knowledge levels, particularly among men, indicating that the general community sensitization efforts have not yet had an impact. This is exacerbated by the lack of clear, pregnancy related messages for danger signs, birth planning and post partum care.

At the community level, key messages were buried in a TBA training curriculum that was based on the national curriculum developed pre-1994. Although updated, it provided too

much information and not enough of the essential information. There is still confusion over using the risk approach for pregnancy screening and TBAs were oriented to managing adverse presentations. This is instead of focusing on the assumption that every pregnant woman is at risk and using the model of the four delays (delay in recognizing there is a problem, delay in deciding to seek help, delay in getting to care, and delay in getting the appropriate care in the health facility) to design community level interventions that will facilitate effective transfer in case of complications. There is also very limited emphasis on post partum or essential newborn care. While the need for access to gloves has been identified as a priority by TBAs, the distribution of CDKs is delayed because they were not prioritized by project management.

At the health center level, the opportunity to use the first pre-natal visit to emphasize birth preparation, danger signs, and clean deliveries seems to be seriously underutilized. The content of pre-natal care is not oriented towards danger signs and birth preparedness, and there is little to no emphasis on post partum or newborn care.

Finally, the need for access to family planning was expressed at both the community level and health center levels. Providers expressed the need for training in managing modern methods and addressing side effects. Access to modern methods is particularly challenging because four out of seven of the project health centers are run by the Catholics. The District is interested in piloting an outreach approach, using MOH-paid staff from the Catholic centers to provide family planning services at an off-site location.

Recommendations

- *Revise Safe Motherhood Strategy for the District based on international best practices. Revise the TBA curriculum to emphasize essential messages and behaviors accordingly. (danger signs, birth planning, clean delivery, post partum and newborn care, etc.)*
- *Orient health center providers in the essential elements of pre-natal post partum and newborn care according to international standards.*
- *Immediately distribute and promote the use of clean delivery kits.*
- *Train health center staff in family planning and develop an outreach strategy to cover the Catholic areas.*

C.4. Nutrition

The majority of malnutrition in the project area is chronic, mild to moderate – a condition that lends itself to home and community management. The project strategy for addressing community level moderate malnutrition is to establish community growth monitoring with group sessions using the Hearth Positive Deviance model as an intervention for faltering children. So far, three community growth monitoring sessions have been established in one health center zone, and staff in that zone (both project and MOH) have been trained in the Hearth model. Another child survival project in Rwanda has successfully started a Hearth program, and people are enthusiastic about the possibilities. For severely malnourished children, the project will be referring them for hospital care since the World Food Program feeding centers have recently closed.

Unfortunately, the three growth monitoring sessions were begun before adequate preparations had been completed. The promised worm and iron medicine has not yet been procured due to internal project management problems, and the Hearth model groups are not yet in place as an intervention for malnourished children. As a result, enthusiasm and attendance are tapering off and it may be difficult to revive.

Because of the pilot approach focusing on one health center area, the overall scope of this intervention is still very limited. There is no general knowledge among either activists or community health cadres on nutrition prevention, nor are key nutrition messages included in case management at either the community or health center levels.

Recommendations

- *Immediately procure the necessary supplies to assure function of the growth monitoring sessions.*
- *Link the Hearth model intervention to any community growth monitoring activities in order to assure a positive intervention for malnourished children.*

D. Cross-Cutting Approaches

While technical interventions were mostly on the right track, particularly the HIV/AIDS and malaria interventions, the project seemed to lack overall coherence in its strategies. By "piloting" different interventions in different areas, and by working from a general list of activities and target groups, essential messages and behaviors were not integrated across the project interventions and they tended be diluted throughout the project area.

D.1 Behavior Change Strategy

There were some preliminary successes with behavior change mobilization. These included significantly increasing demand for both insecticide-treated bednets and VCT/PMTCT and increased promotion for ANC and institutional deliveries by trained TBAs. However, the general BCC strategy seemed to start with a list of information and activities to promote, rather than taking a more rigorous approach starting with the desired behaviors and defining essential information and target groups from there. As a result, project energy was dispersed over a variety of target groups (teachers, anti-AIDS clubs, PLWAs, TBAs, animators, traditional healers, and health center providers) and was concerned with providing them a wide range of information. Neither the information nor the target groups were necessarily focused on the most efficient means to achieving the desired behavior change. As mentioned in the previous sections, the lack of message focus was particularly apparent for the MNH and nutrition interventions. Similarly, the work with the traditional healers, primary school teachers, and anti-AIDS clubs is probably not directly related to project outcomes, and contributes to a general lack of focus in project activities.

With respect to health education materials, the project reproduced a flip chart for each of the interventions and distributed a full set to each health center. These were nicely done

and appreciated by health center staff. A duplicate set was also provided to each health center for use in the communities. Unfortunately, they were big and bulky such that they were not transported to the field, and animators did not go out of their way to come get them. There were no other health education materials available at the community level for use by the animators or TBAs in their health education activities.

Recommendations

- *In partnership with the district, identify and integrate the key behaviors for the four intervention areas and elaborate/implement a behavior change strategy.*
    - *Identify a package of key messages to be delivered consistently throughout the project*
    - *Consider limiting project effort and activities in the mobilization of traditional healers, teachers, and anti-AIDS clubs since this tends to dilute project focus.*
- *Identify and prioritize the extension of successful pilot activities such as growth monitoring/Hearth, VCT, PMTCT, and TBA training. Given the limited time left, realism as well as effectiveness will need to be considered.*
- *Provide IEC materials at the community level through identification and replication of existing materials in the country, producing new ones only as a last resort.*

D.2. Training

A lot of training has been done for this project. Representatives staff and partners were trained in different interventions based on the specific project activities they were responsible for implementing. Exchange visits to other child survival and Concern projects also complemented the training approach, offering participants a direct experience of the interventions in addition to the technical content. Finally, the project joined with the other child survival projects to sponsor an early training in adult learning methodologies. This was a positive step towards improving the quality of project training. As a result of these efforts, the project activists were generally recognized as competent, and their skills were appreciated by the health centers.

In spite of the effort, the lack of a focused BCC strategy as well as the pilot approach to implementation negatively impacted the focus and impact of training. For each intervention, there was a tendency to train a few representative people with too much, relatively unfocused information. As a result, the project lacked a critical mass of people across cadres and interventions who had been trained in a core of essential information. In addition, despite the initial effort to focus training using adult learning methodologies, staff turnover and the lack of follow-up meant that the impact of that training was limited.

The training strategy depended on the ability of the activists to carry out cascade training at the community level with the involvement of the health center staff. However, specific training curriculum, budgets, or schedules were not provided for these trainings, nor were the activists and health center staff supervised in these efforts. As a result, the training of the community cadres was inconsistent, depending on the capacity and commitment of the particular activist and health center staff as well as on their availability to complete the training program.

Finally, also due to staff turnover, the district does not currently have a complete cadre of counterpart trainers in the different interventions to support ongoing training at the health center and community levels.

Recommendations

- *Provide refresher training to all essential trainers and project staff in order to implement the revised behavior change strategy*
- *Using activists and health center staff as trainers, reinforce the cascade training strategy for the revised behavior change strategy with specific training curricula, schedule, and funding for community level training. District / CSP staff should provide training supervision and support for quality assurance.*

D.3. Community Mobilization

The primary strategy for community mobilization is recruitment, training, and formation of community volunteers into associations. The health animators are responsible for general community health education, distribution of condoms, and will eventually be responsible for community-based treatment of malaria and/or broader distribution of ITNs. The TBAs are responsible for education around pregnancy and delivery as well as carrying out clean, safe deliveries. The project has also supported the national policy for the establishment and support of mutuelles and health committees.

Associations

Forming community volunteers into associations is an innovative approach to providing continuing education, motivation and the potential for sustainability for community volunteers. They target existing cadres of community volunteers (animators, TBAs, and traditional healers) rather than establishing or recruiting new ones. Most of these associations seem to be meeting monthly with support from activists and sometimes health center staff. These meetings are used as a forum for providing education and follow up, distributing supplies such as condoms, and for encouraging generation of monthly reports on community indicators. In some areas regular meetings, particularly of health animators, were taking place before the beginning of the project. However, the project's reinforcement of these meetings, and the formation of these groups into associations with membership and a means to generate funds has strengthened them.

While support for these structures seems to be generally moving forward, there was some question about whether these structures are actually getting essential messages to the household level. The majority of a very small sample of recently delivered mothers had little to no contact with any of their community volunteers, and most of their information had come from the health center during pre-natal visits. Different associations also don't seem to have much contact with each other, reinforcing the idea that the project activities are not very integrated across the different interventions. If these associations can be reinforced in their roles and responsibilities through training in a more focused BCC strategy training, and if they can provide a forum for motivation and coordinating with other cadres, they could have a significant impact. This will be increased if the messages promoted in the health centers are the same as those at the community level.

Recommendations

- *Make sure the community worker activities are focused, limited, and consistent with the BCC strategy*
- *Continue to develop a motivation strategy for community volunteers*
    - *Strengthen and reinforce the animator and TBA associations as a forum for increasing motivation and even generating income*
    - *Consider making ITNs and/or other supportive working tools available to volunteers based on performance*
    - *Consider payment for volunteers attending training to compensate for time and meals (even cascade training)*

Mutuelles / Health Committees

Project support has coincided with national momentum such that there are now mutuelles and health committees in all seven of the project health centers. The members seem to be generally well selected, are interested in their work, and tend to be involved in other community activities. There is healthy overlap between the mutuelle and health committees, and both include animators. Committee members seemed to be clear about the relative roles and responsibilities between the two committees, with the health committee responsible for health center management issues in general, while the mutuelle committee is responsible for its members.

There is good local government support for the mutuelle effort through guarantee of bank loans for membership fees, and with local government representatives assisting with community promotion. While intensive effort has only occurred during the last three to four months, membership seems to be growing rapidly. Unfortunately, the training of trainers for mutuelle management was done two years ago and staff has subsequently turned over. As a result, the mutuelle committees have not yet been trained and the project needs to start over with training trainers. Meanwhile, they are carrying out money management activities for which training is urgently needed. Also, despite the national availability of recently standardized mutuelle management tools, the committees do not yet have access to these tools.

At the district level, the project had planned to support the establishment of a district health committee. In the course of discussion, including discussion with the Provincial Health Director, it became clear that there did not seem to be a role at this time for such a committee. Rather, it risked becoming an expensive, bureaucratic committee with its coordination functions better handled elsewhere.

In contrast, discussion also indicated that it might be helpful to establish some kind of mutuelle federation to address mutuelle issues at the district level. Implementation of the mutuelles is inconsistent across the district, with significant variation in both membership fees and benefits. People felt that a forum to begin to address these variations, to consider the level of mutuelle support for hospital services, and to standardize the mutuelle messages at the community level might be helpful.

Recommendations

- *Train trainers and train mutuelles as soon as possible, bringing in the standardized national management tools.*
- *Develop a confederation of mutuelles at the district level to work towards consistent mutuelle policies and to develop a strategy for coverage of hospital services. This focus allows the District health committee to be postponed indefinitely.*

Collaboration with Local Government

The project has somewhat overlooked the potential role of local government in community mobilization and sensitization for health. While local mayors were aware of the project, they had not been requested to provide assistance at the community level except for their support of the mutuelles. While thought needs to be given to the training load and the need for ongoing support to a large cadre of personnel, there may be ways the project could make better use of this structure. One idea was that local government unit below the cell level (nyumba kumis) could potentially provide follow up for children who are treated for malaria at the community level.

Recommendation

- *Explore ways to increase the involvement* of the local government structure with *community child survival activities.*

D.4. Partnership

The primary project partners are at the district and health center levels. However, the project has also developed partners at the national level. These have grown out of a child survival coordination group involving the other two child survival implementing agencies. This group provides a forum for sharing ideas, sharing consultants for training, and an opportunity for capacity building through invitation of other national experts to participate in technical discussions. Specifically, this group shared consultants for the training in adult learning methodology as well as the Hearth training. The national child survival group was the also means through which the project became involved with the national malaria program which was discussed in the malaria section.

District Level

Project staff make an effort to coordinate activities with those of the district. They participate in weekly meetings with district staff covering discussion of planned project activities. District staff were involved in the initial project design discussions, and continue to be involved in developing coordinated annual plans. Representatives from the MOH have also been included in all project trainings, and there have been hopes of doing joint supervision, although this has not yet been done.

One of the project strengths has been its ability to respond to specific district needs, even when they weren't initially planned. The first of these was a meningitis outbreak that occurred during the first year. The project identified the outbreak early and was able to assist with both surveillance and an immunization campaign. The second example of

such responsiveness was the procurement of an ambulance for the district. While motorcycles for health center managers were planned in the project, the district identified the purchase of an ambulance as a greater priority. As a result, money was reallocated and the ambulance was procured. This ambulance is currently the only vehicle in the district, although others are in the pipeline.

The project has suffered a high level of staff turnover, particularly in management positions. The resulting vacancies and limited level of remaining staff, have meant that the project's ability to support the district and increase its capacity has been compromised. Consistency in managing the partner relationships has also been lacking.

Several people reported that the previous District Medical Officer (DMO) contributed significantly to partnership difficulties. He had a tendency to look at agreements with his own self-interest in mind, to threaten Concern staff with retribution to the program if they didn't do what he wanted, and to be generally unavailable particularly after mid-day. All parties – Concern, USAID and MOH were aware of this issue and all had to wait patiently until September 2003 until the DMO was transferred from the post. Needless to say, trying to develop and strengthen a partnership in such a situation was a huge undertaking and was immensely frustrating.

The new DMO expresses the perception that Concern is not meeting its agreements with respect to District support. In spite of receiving the ambulance, the District perceives that Concern is not meeting its commitments to making transport, District fuel supply, office support for a Kibilizi office, or essential materials available. This is probably due to a variety of reasons including lack of sufficient orientation of the DHO to the project and its limitations, inadequate project management of administrative systems within Concern thus limiting Concern response to District needs, and Concern's recent manpower shortage due to staff vacancies. The recent arrival of a new DMO and a new project coordinator, both of whom are committed to the success of the project, means the relationship should be stronger in the months to come.

Health Center Level

The model of attaching project activists who are focused on community activities to each health center increases the health centers' capacity to support these activities. Activists are involved with organizing and supporting associations and doing outreach activities in the communities. Everyone valued the community activities, seemed to appreciate the model and felt the activist role was important.

Unfortunately, there was a problem with activists spending a significant amount of their time away from their health centers. This was due to a variety of reasons related to short-staffing, prioritization of other projects and studies, and a general lack of commitment to their field presence. Also, with their primary accountability to project staff, in some cases there tended to be a lack of communication regarding their program and commitments with the health center staff. The strength of this model is the opportunity to develop a counterpart relationship with health center staff in order to increase their orientation towards community activities. The potential for this relationship, with the joint

recognition that both the health center and project staff share the same goals and job, is underexploited.

Another concern with the activist role at the health centers was the lack of planning for devolution and the challenge of sustaining the community activities after the end of the project. The activists tended to focus on the head person at the health center rather than on the whole team. This centralized the burden for community support on one person and made the potential for sustainability dependent on that person remaining at the health center to support community activities. In addition, even though payment of actual per diem for field activities was recognized as outside the policy, people acknowledged that a small allowance for something to eat or a snack might be in order if health center staff were expected to be in the field all day. The health committees might be expected to support this kind of expense, but up to now they tend to focus their support on health center-based curative activities more than community activities, largely because they have not been oriented otherwise. Also contributing to the concern about sustainability was the observation that there were a couple of Catholic health centers where the head person emphatically did not see community activities as part of their responsibility.

While it is not likely that the MOH will plan to fill the position of the activists, several ideas to improve the chance for sustaining community activities were discussed. These included encouraging the activists to work with the whole health center team rather than just the person in charge in order to "spread the load", and orienting the health committees to the community activities with the hope of encouraging them to begin to support them. An additional suggestion to support the health committee involvement was for the project to give a small sum of money earmarked for supporting community activities to the health committees to manage. They would need to plan for these activities with the activists, this would contribute to the sense of two-way partnership or ownership for the activities, and accounting for its use would raise the profile of supporting community activities. Finally, planning on leaving the activists' motorcycles in the health centers at the end of the project would also help assure transport to support community activities.

The project had expected to be more involved with health center capacity building. To this end, a HICAP facility assessment had been planned. It has become apparent that with the exception of assuring familiarity with essential messages at the health center level, and of addressing a few specific treatment issues such as malaria treatment and pre-natal/post partum care, the project will probably continue to maintain its focus at the community level. As a result, the HICAP is no longer very pertinent, and it is essential for the project to get on with the implementation activities at the community level.

Recommendations

- *Review and adjust the memorandum of understanding to clarify expectations of current partners.*
    - *Make sure project equipment in the field stays there after the end of the project to assure support of community activities (e.g. the activist motorcycles)*

- *Involve the full health center team in support of community activities and have the activist orient them during the remainder of the project.*
    - *Where feasible, provide a small budget to the health committees to support health center staff's field visits as a means to increase their commitment to community activities*
    - *Health center staff and activists should jointly develop a work plan for community activities every two weeks It is then the responsibility of either partner to inform and justify changes to the other.*
- *Make project documents and technical resources available at the district level such as in a small library.*

D.5. Monitoring and Evaluation

In general, the project monitoring and evaluation system was well designed and beginning to generate information that indicates progress on project objectives. Both the animators and the TBAs are currently generating their reports, providing information on community activities that complements that generated by the MOH at the health center level. When asked, animators acknowledged that the data they are generating helps them evaluate themselves and the job they are doing. Several studies including baseline and midterm surveys, a participatory appraisal, and a study on gender were done to complement other project information. A special assessment was also done to determine actual bednet utilization to be sure the nets that were sold were being used by the targeted population. This was a good example of rapid operations research responding to a specific question that effectively complemented routine data. A copy of this study is included as a special highlight in the project's second annual report.

Unfortunately, the project has been slow to actually generate and share the reports from the data they are collecting. This has partly been due to occupying the M&E officer with administrative activities. However, active sharing and discussion of information is not taking place at either the health center or the district level. Some MOH staff even shared the perception that they share their numbers with project staff, but that project staff don't share their information in return.

Recommendation

- *Project and MOH staff should work together at health center and district levels to share numbers, discuss progress, and develop one quarterly report*.

D.6. Gender

To its credit, this project made an effort to design gender into its strategy. It began with a study on gender issues as they pertain to child survival, and followed with the development of training on gender. However, there seems to be no actual impact from these activities. The approach was somewhat superficial for both the study and the training, and the training did not include the experiential or reflective approach that is essential for changing attitudes.

Given the organization's commitment to gender and the maintenance of a cross-cutting gender specialist position, this intervention will probably continue to be encouraged.

However, given the other project priorities, it should probably not be a priority within child survival itself. That said, if the cross-cutting Concern gender activities have access to technical support for planning and implementing participatory training activities using as experiential approach, the theme is very relevant to the project and the opportunity should be used to further develop the integration of the gender perspective with project approaches.

D.7. Sustainability Strategy

The DIP outlined a detailed devolution strategy that focused on how the MOH would take over responsibility for ongoing training and support of community activities. The plan did not really focus on the essential elements for supporting continued implementation of the desired behaviors at the household level. In addition, with a nearly complete turnover of staff since DIP development, it was relevant to revisit the plan for sustainability. This was done as the last step in developing the action plan.

Three elements were defined that will determine project sustainability: the maintenance of the desired behaviors at the household level, the maintenance of community structures that support these behaviors, and the maintenance of health services at the health center that also support these behaviors. At the household level, the project objectives define the desired behaviors. It is unlikely these will be self-sustaining after the end of the project if the support services are not maintained.

Support structures at the community level include the associations for the health volunteers, the mutuelle and health committees to help assure access to services, and supervision from the health centers for these activities. Brainstorming of sustainability indicators for these structures included:

- Associations and committees continue to meet independently without the activist
- Members of associations and committees are well trained, link with existing health structures, and have access to a minimal motivation system.
- Health center staff provide field supervision of community activities without project support. An intermediate indicator would be the health committee managing funds to support community activities – even if the funds are from the project.

Continued access to services both in the community and at the health center are an essential element of maintaining the desired behaviors. Indicators suggested for these included:

- Purchasing and logistics systems in place through the District to assure essential supplies
- Regular supervision and quality improvement efforts without project support
- Ongoing provision of specific services according to care standards: VCT, PMTCT, pre-natal and post-partum care according to international standards, malaria treatment according to protocol, provision of modern family planning methods, growth monitoring with positive deviance sessions for malnourished children, and sale of impregnated bednets.

The project will further consider these indicators in more detail during preparation of their annual reports, and after having completed the project focusing process recommended during the next few months.

Aside from this framework, other activities contributing to sustainability include the encouragement of mutuelle pre-payment schemes to support access to health services, and the orientation of the health committees toward supporting community activities.

E. Program Management

While the overall proposed activities are generally on schedule and it looks like the project should achieve nearly all of its objectives, the evaluation raised concerns about project efficiency as well staff performance and retention. The evaluation revealed issues regarding planning at the project level, communications between the project staff and the area manager/Kigali, and user-friendliness of the administrative and management systems. While the evaluation team did not have sufficient time to look into these issues in depth, it was perceived that these issues may be hampering the efficiency of project delivery and contributing to disruptive staff turnover.

E.1. Planning

Early project planning involved a wide range of participants at the district, provincial, and national levels. Subsequently, partners, particularly at the district level, have been involved with development of annual work plans, monthly planning and weekly coordination meetings. Bi-lateral planning meetings are also held at the Provincial level with the Ministry of Health, GTZ, Health Net, and Concern. Budget and spending review is not part of any of these meetings.

As discussed in the behavior change section, the project implementation plan will be reviewed and adjusted based on a revised the BCC and training strategy. The over-elaboration of DIP details during initial project planning may have contributed to the lack of cohesion in project strategy.

New staff, either for MoH or for Concern, have not had consistent orientation to the project and its objectives and limitations. Key project documents are not generally available, although they were translated and were reportedly provided to the MOH at the beginning of the project.

E.2. Human Resources

Personnel policies were clear and available, and staff felt that the recruitment processes were fair. They saw this as a strength. The project has prioritized sending the Coordinator to participate in the Core Annual Meeting to ensure the quality and innovation of the programme strategies. Concern has a staff development policy supporting education fees

for staff who go back for advanced education or who seek additional learning opportunities. Currently some staff are currently supported for English and Clinical Psychology courses at the University of Butare.

The actual distribution of management and administrative responsibilities was a significant constraint for project implementation. No one in the project has administrative functions in their job description. This, combined with the recent project vacancies, led staff who had field responsibilities to increasingly shift their time and effort towards the administrative needs of the project. During the period of the Acting Project Coordinator, many of these tasks were delegated to field staff such as report writing and cash handling for project activities. However, field staff also seem to have been hesitant to fully establish themselves at the field level. Contributing to the problem, there was no field-level supervision of staff during most of this interim period.

As mentioned previously, staff turnover has plagued this project, particularly at the middle and senior management level. This left lower level staff without adequate supervisory and technical support. It also left lower level staff acting in management positions for which they were not qualified, although senior management in Kigali and New York provided additional support to try and offset this constraint. While low salaries were mentioned by staff and government partners as a contributing factor to attrition, the management system, volatility of staff itself, lack of delegation to local management staff, and frustration from the unclear division of responsibilities between administration and program probably also contributed.

Staff turnover is also exacerbated by market competition for highly skilled staff from increasing volume of highly funded bi-lateral projects. Two of the three mid-level departures were staff who went to work for the Ministry of Health donor-funded positions. This has had a positive unintended consequence of capacity building and partnership building between the MoH and the project. For example, the evaluation benefited from the full-time participant of one of these staff who was now representing the regional MoH.

E.3. Logistics and Support

Concern Rwanda has fairly centralized administrative systems and allocates resources by an administrative structure that may not be aware of immediate program needs and priorities. Project staff bear some responsibility for this problem as they do not adequately plan nor communicate their needs with administration. The status quo of the staff management style within the context of Concern's administrative and finance system appears to be posing significant constraint to project implementation. Staff complain that cars aren't available for the program when they have been planned for, that procurement of supplies is delayed, and that it is sometimes unclear, particularly to lower level staff, "who is responsible for what" between the program and administrative staff.

Another significant issue has been the location of the project office in Butare. While there was an effort to provide the generator and fuel to make an office in Kibilizi feasible by the Country Office, the momentum tapered out with the departure of the Project

Coordinator last year. Having the office in Butare offers an additional excuse for field staff not to stay in the field, is an additional barrier to field supervision, and is a lost opportunity for coordination with District staff.

E.4. Financial Status

As of the end of December, the project had spent 88% of its projected expenditures. The under-expenditure was largely due to the unfilled Coordinator position through most of the past year. While spending was projected based on the project activities rather than spread evenly over the five years (and the budget for the last two years is therefore lower), it is probable that spending is on track, with enough extra money to hire an additional person as a field supervisor. A budget revision will likely be necessary once the BCC strategy, training plan, and project priorities are revised.

E.5. Backstopping

This project has received excellent backstopping from Concern's New York office. There have been a total of five technical visits and 2 administration/finance visits to fill in gaps in the project. These visits have been sincerely appreciated by everyone concerned, and have provided continuity in the face of the staff turnover on the ground. A complete list of the technical visits including the topics that were discussed is attached in Annex 8.

Recommendations

- *Conduct an objective internal management review addressing project planning, communications and country office management systems. This review should include interviews with former staff.*
- *Decrease the administrative responsibilities of the activists so they can really spend their time in the field.*
    - *Decrease their regular meetings to two times per month and hold them in Kibilizi*
    - *Review and adjust the organizational chart to assure regular field supervision and to cover administrative tasks without drawing on field staff.*
- *Assure regular supervision and follow up of field activities at both the community and health center/activist level.*
- *Move the entire child survival team to Kibilizi to improve coordination and partnership, making the necessary equipment and logistic arrangements for this to work.*
- *Child survival logistic support should be more timely and responsive:*
    - *Materials and supplies should be available before starting technical activities*
    - *Administration should be involved with project planning in order to prioritize and provide adequate logistic support and/or management of project resources should be decentralized to allow the project to plan for and control their disposition.*

- *While the salary committee should continue to work on adjusting the salary structure, other variables that influence retention should be identified and considered. Exit interviews should be institutionalized..*

F. Overall PVO Capacity Building

Concern has seriously taken the opportunity offered by the child survival grant to strengthen their worldwide health programs. They have gone from one to three health staff, are taking the technical challenges of health programming more seriously, and are developing ways to effectively integrate health issues into their other programming efforts.

In 2001, an institutional strengths assessment identified the need for a child survival health backstop and to establish health "unit". A follow-up institutional assessment in 2003 indicated there had been significant improvement. The health backstop had been hired, health staff had increased, and health staff were actively involving other staff such as desk officers and regional staff in health updates and review of state of the art information. The monitoring and evaluation of health programs, the level of community participation, and the efficiency in project start-up had also improved. The health unit now focuses on assuring the quality of health programs while orienting others in the organization to health issues. The organization as a whole is still getting used to its new role in health systems strengthening.

During the second strengths assessment the field attributed considerable capacity to headquarters staff without recognizing their own capacity. This is probably indicative of continued field weakness in program design and management, which puts pressure on backstop staff to provide direct program support in additional to their technical quality assurance function. The salary structure and corporate culture issues mentioned above may make it difficult to upgrade field staff to the extent needed to function in a partnership / capacity building role.

The health unit is currently focusing on continuing to educate the organization on the requirements for child survival projects, using child survival as a catalyst for organizational learning around elements of quality program design and implementation. They are moving towards establishing a forum for annual regional sharing of health programs, are establishing a web site for health, and the health unit is increasing its confidence in pushing for the adoption of international standards in its health programs.

G. Conclusions and Recommendations

In conclusion, strengths of this project included significant progress towards the implementation of the project interventions, particularly for malaria and HIV/AIDS. The model of attaching a project activist to each health center to catalyze community activities and effective health center responses was well received with the potential for strengthening the health center's ability to support health activities at the community level. The establishment of volunteer associations offered an innovative approach to strengthening volunteer activities through providing a forum for continuing education as well as the potential for motivation through income generation options.

The project has, however, suffered from constraints associated with high staff turnover, challenging partnerships with its MOH partners, and a tendency towards overly diffuse strategies and interventions. During the remainder of the project it will need to emphasize its community level strategies through a refocused BCC and training strategy, prioritizing the partnership between the activist and the health center teams, and supporting the associations' efforts to reach the household level.

A consolidated list of recommendations is attached in Annex 1.

Highlights

Associations of Persons Living with AIDS

Working through the Catholic sisters, this project has provided significant support to two associations of persons living with AIDS (PLWAs). There is a palpable energy when meeting with these people. Despite being some of the most poor and outcast people in African society, these people have a purpose for living when they are meeting and working together – and it is noticeable.

People say:
"Now we have hope. We can live a positive life and send our children to school. Before we had lost hope".
"Before we were isolated and shunned, but now we have the group we are not so bothered".
"When I first found out I was angry and wanted to have sex with everyone, but now I realize I have to be responsible to help protect others".
"We now have strength to tell the message (about HIV prevention) everywhere".

These associations provide a social forum where people who are otherwise stigmatized and outcast can belong and feel worthwhile. They feel empowered to provide testimonials and to speak out in their communities for AIDS prevention. They educate people about the inability to recognize HIV positive people by looking at them, and convince them that AIDS is a reality. They also indicate that while some community members are still prejudiced against them, they feel the stigma is decreasing as they are increasingly able to speak out.

These associations also provide income generating activities with income being used to pay for drugs to treat opportunistic infection. One association established a small shop out of the health center with the child survival project providing a small grant for the initial capital. Unfortunately, with the growth of the association, members are realizing that the shop is not generating enough income to cover their medicine needs, so they are now looking for additional activities. Goat raising and purchase of a mill have been among the suggestions, and consideration is being given to encouraging the association itself to apply for funding for the mill.

These associations have not always offered this same positive outlook. When first formed, members tended to feel lost in their own troubles and hopelessness, finding it difficult to reach out to the suffering of others. Members were not feeling supported by their families or communities, and the burden of the disease seemed overwhelming. Family and community support for members is still limited, but the personal transformation that has occurred through the process of accepting their situation and moving on to actively reach out to change things in their communities has now given members a reason for coming together and a reason for continuing to live.

Adoption of Mosquito Nets

One of the universally recognized strengths of this project was the access to and use of insecticide treated mosquito nets by pregnant women. Because the nets were being sold at a significantly subsidized price (200 FrR as contrasted to 1000FrR on the general market) the project did a follow-up study to be sure the nets were actually being used by the targeted pregnant women and newborn babies. Indeed, the survey, the monitoring system, and the mothers encountered during the evaluation all indicate that women in pre-natal care were buying and using insecticide treated mosquito nets.

Of particular note was the response of individual women during the evaluation when they were asked why they weren't selling their nets for a profit. The inevitable response was a laugh and clear communication that that was a ridiculous idea. They indicated they liked sleeping under the nets, appreciated not being bothered by mosquitoes, and that the nets were used by the woman herself, her husband, and the newborn baby.

Next Steps

The final day of the evaluation was spent meeting with all of the child survival staff and most of the district management team to identify next steps and begin to develop an action plan based on the recommendations of the evaluation. The foundation for the remainder of the project will be a refocused behavior change strategy, using the BEHAVE framework, that will identify the essential messages and effective messengers and target populations for the project interventions. This will provide the basis for a reoriented training plan and a prioritization of project activities for extension to a broader project area. This strategy will hopefully be developed in April with collaboration from the MOH partners. Timing will depend on the availability of the project backstop and national commemoration events. In the meantime, project staff will begin working on some of the smaller, more technical recommendations.

The next steps for the three unfinished interventions (malaria, MNH and nutrition) and a timeline for the activities was developed during the week following the departure of the consultant (see attached 6-month workplan).

Project / Team-wide Activities to Focus the Project

- Use the March meeting with activists and health center staff to work on relative roles and responsibilities and team building. This should be carefully planned in the context of the partnership recommendations to maximize the team building elements.
- Organize a meeting soon (in April?) to rigorously develop/review the behavior change strategy in order to assure the project is maximizing its efforts.
    - This should lead to development of essential focal messages and identification of the most important change agents.
    - Integration of the essential messages for all four interventions should be part of this exercise.

    - Make sure the project messages and strategies are at least consistent with community IMCI – even if the project isn't doing all the elements.
    - Review the list of project activities in terms of their relative success, level of effort, and level of importance relative to community health needs to determine which activities will be replicated and where.
- Organize training for key messages and competencies identified through the BCC review:
    - Using adult participatory learning principles, develop concrete training materials the trainers can use with the targeted community trainees
    - Develop an overall training plan and budget for training during year 3.
    - Train trainers (health center staff, activists, and representative health committee members) on the BCC messages, behaviors, and training materials. (health committee members will learn the importance of community activities)
    - At the end of the TOT, each health center team should identify a training plan for training the targeted community groups (animators, TBAs, other?)
    - With project funding, health center teams will then train targeted community health workers in key messages.

- Increase the availability of IEC materials at the community level by:
    - Distributing those that are remaining
    - Identify and review materials already available in country through other projects of the MOH
    - Procure or replicate those that are pertinent to project activities and distribute to community workers.
- Develop a forum for CHWs to meet together and interact at the cell level (after this next training phase)
- Review additional needs for CHW motivation after the intensive project inputs of the coming 6-8 months

Activities for Strengthening the Partnership

- Review and adapt the Memorandum of Understanding since new partners are involved. Plan for devolution (equipment distribution) as part of the process.
- Immediately begin joint planning between activists and health center staff to identify and prioritize two-week work plans and to increase mutual accountability. Plans should include a plan for transporting VCT samples where needed.
- Develop a plan to make the health committees (with project financial support) responsible for working with activists and health center staff to assure health center involvement with community activities.
    - Train health committee representatives in project interventions (see first section)
    - Determine the small amount of money that will be needed on a monthly basis to provide snacks for health center staff if they are spending a full day in the field supporting community activities and give control over the

planning and dispensation of this money (and accounting for how it was used?) to the health committee / activist / health center team.

- Work together at all levels on reporting and using data:
    - Generate a timely quarterly report and share it with the District management team.
    - Make sure the project HIS is consistent with that of the MOH (it was designed with this in mind)
    - Work with health center staff and activists to develop and discuss monthly report together before submitting. The health center staff meeting could provide a forum for discussing the data.
- Open a project office in Kibilizi
    - Assure the availability of power and communication (phone?)
    - Identify appropriate office space
    - Provide a computer

Intervention – Specific Actions

- Mutuelles:
    - Train trainers for mutuelle training
    - Procure standard management tools for mutuelles
    - Train mutuelle committee members in management
    - Form District confederation of mutuelles, and health and district administration to work on standardizing the plans across zones.
- Confirm with District and Province partners that the District health committee will remain on the back burner.
- HIV/AIDS
    - Contact MAP and USAID to determine the potential for developing support for community associations such as the PVV associations – particularly in relation to income generating activities. PEPFAR may be an alternative for additional funds. (be sure to add additional staff to manage this component)
    - Meet with TRAC to assure the timely availability of quality control results and the continuous availability of testing reagents.
    - Meet with MOH/Kibilizi and the project to establish a fixed calendar for transporting quality control samples and a plan for assuring transport to meet the plan. (this involves CSP coordination with administration as well)
- Maternal & Newborn Care
    - Immediately distribute and promote the use of clean delivery kits and inform men and women about contents and price.
    - Develop safe motherhood and newborn care strategy for district with external technical assistance
    - Revise the TBA curriculum to emphasize essential messages and behaviors according to international standards (danger signs, birth planning, clean delivery, post partum and newborn care, etc.)

- Orient health center providers in the essential elements of pre-natal post partum and newborn care according to international standards
- Train health center staff in family planning and develop an outreach strategy to cover the Catholic Health Center areas.

Nutrition

- Immediately procure the necessary supplies to assure function of the growth monitoring sessions in Gikore.
- Train remaining staff and partners in nutrition and PD/Hearth
- Link the Hearth model intervention to any community growth monitoring activities in order to assure a positive intervention for malnourished children.
- Scale-up sites to 3 cells per Health Center zone

Malaria

- Continue contributions to national committee for community based malaria treatment
- Facilitate selection of additional distributors at the cell-level
- Prepare training plan for district and assure availability of drugs prior to launch of activity in June 2004.

Management

- Prioritize the presence of the activists in the field:
  - Review roles and responsibilities of different staff including the overall organogram and lines of authority in order to assure that activists are not doing any administrative activities. Make adjustments in staffing and job descriptions where necessary.
  - Make sure the supervision and support (including supplies) for activist activities are effectively covered.
  - Make sure transport policies support the maintenance of a motorcycle with every activist, and the ability of the activist to also transport a health center staff person to community activities.
  - Develop an indicator to measure whether activist presence in the field is being achieved. (e.g. after one month, the activists will be spending at least 4 days in their health center zones unless other activities are specifically included in the two week work plan)
- Establish a CSP office with a staff in Kibilizi (see above)
- The project coordinator needs to increase the project voice in administration:
  - Regular coordination and communication with the area administrator
  - Participation in the senior management team
  - Staff retention plan – push salary adjustment
    - Work towards more horizontal / participatory management style

A six-month work plan is attached in Annex 2.

Annex 1 - Synthesized List of Recommendations and Next Steps

Technical Recommendations

HIV/AIDS

1. Assure timely transfer of VCT quality control samples to Kigali on a fixed schedule and negotiate with TRAC to assure timely return according to schedule
2. Expand and support the PLWA activities (including home visits to promote participation, request permission to notify other staff of results during post test counseling,)
3. Explore MAP funding for PLWA associations and existing anti-AIDS clubs as a way to provide additional financial support and income generating activities. Consider transfer of the school-based activities and the Anti-AIDS clubs to other programs such as education or the integrated AIDS program.

Malaria

4. Expand the availability of ITNs to the general population even if the price isn't subsidized. This will be facilitated shortly with the importation by government of permanently treated nets at more reasonable prices. Under five children and PLWAs should be particularly targeted.

MNH

5. Revise the TBA curriculum to emphasize essential messages and behaviors according to international standards (danger signs, birth planning, clean delivery, post partum and newborn care, etc.)
6. Orient health center providers in the essential elements of pre-natal post partum and newborn care according to international standards
7. Immediately distribute and promote the use of clean delivery kits.
8. Train health center staff in family planning and develop an outreach strategy to cover the Catholic areas.

Nutrition

9. Immediately procure the necessary supplies to assure function of the growth monitoring sessions.
10. Link the Hearth model intervention to any community growth monitoring activities in order to assure a positive intervention for malnourished children.

Cross-Cutting Recommendations

BCC strategy / Training

11. In partnership with the district, identify and integrate the key behaviors for the four intervention areas and elaborate/implement a behavior change strategy.
    a. Identify a package of key messages to be delivered consistently throughout the project

b. Consider limiting project effort and activities in the mobilization of traditional healers, teachers, and anti-AIDS clubs since this tends to dilute project focus.

12. Identify and prioritize the extension of successful pilot activities such as growth monitoring/Hearth, VCT, PMTCT, and TBA training. Given the limited time left, realism as well as effectiveness will need to be considered.
13. Provide IEC materials at the community level through identification and replication of existing materials in the country, producing new ones only as a last resort.
14. Provide refresher training to all essential trainers and project staff in order to implement the revised behavior change strategy
15. Using activists and health center staff as trainers, reinforce the cascade training strategy for the revised behavior change strategy with specific training curricula, schedule, and funding for community level training. District / CSP staff should provide training supervision and support for quality assurance.

Community Mobilization

16. Make sure the community worker activities are focused, limited, and consistent with the BCC strategy
17. Continue to develop a motivation strategy for community volunteers
    a. Strengthen and reinforce the animator and TBA associations as a forum for increasing motivation and even generating income
    b. Consider making ITNs available to volunteers on credit with payments over time
    c. Pay per diem during training (even cascade training)
18. Train trainers and train mutuelles as soon as possible, bringing in the standardized national management tools.
19. Develop a confederation of mutuelles at the district level to work towards consistent mutuelle policies and to develop a strategy for coverage of hospital services. This focus allows the District health committee to be postponed indefinitely.

Partnership

20. Explore ways to increase the involvement of the local government structure with community child survival activities.
21. Review and adjust the memorandum of understanding to clarify expectations of current partners.
    a. Make sure project equipment in the field stays there after the end of the project to assure support of community activities (e.g. the activist motorcycles)
22. Involve the full health center team in support of community activities and have the activist orient them during the remainder of the project.
    b. Where feasible, provide a small budget to the health committees to support health center staff's field visits as a means to increase their commitment to community activities

c. Health center staff and activists should jointly develop a work plan for community activities every two weeks It is then the responsibility of either partner to inform and justify changes to the other.

23. Make project documents and technical resources available at the district level such as in a small library.
24. Project and MOH staff should work together at health center and district levels to share numbers, discuss progress, and develop one monthly report.

Management Recommendations

25. Decrease the administrative responsibilities of the activists so they can really spend their time in the field.
    a. Decrease their regular meetings to two times per month and hold them in Kibilizi
26. Assure regular supervision and follow up of field activities at both the community and health center/activist level.
27. Move a core child survival team to Kibilizi to improve coordination and partnership, making the necessary equipment and logistic arrangements for this to work.
28. Child survival logistic support should be more timely and responsive:
    b. Materials and supplies should be available before starting technical activities
    c. Administration should be involved with project planning in order to prioritize and provide adequate logistic support and/or management of project resources should be decentralized to allow the project to plan for and control their disposition.
29. While the salary committee should continue to work on adjusting the salary structure, other variables that influence retention should be identified and considered.

Next Steps

Project / Team-wide Activities to Focus the Project

- Use the March meeting with activists and health center staff to work on relative roles and responsibilities and team building. This should be carefully planned in the context of the partnership recommendations to maximize the team building elements.
- Organize a meeting soon (in April?) to rigorously develop/review the behavior change strategy in order to assure the project is maximizing its efforts.
    - This should lead to development of essential focal messages and identification of the most important change agents.
    - Integration of the essential messages for all four interventions should be part of this exercise.
    - Make sure the project messages and strategies are at least consistent with community IMCI – even if the project isn't doing all the elements.

    - Review the list of project activities in terms of their relative success, level of effort, and level of importance relative to community health needs to determine where which activities will be replicated.
- Organize training for key messages and competencies identified through the BCC review:
    - Using adult participatory learning principles, develop concrete training materials the trainers can use with the targeted community trainees
    - Develop an overall training plan and budget for training during year 3.
    - Train trainers (health center staff, activists, and representative health committee members) on these messages, behaviors, and training materials. (health committee members will learn the importance of community activities)
    - At the end of the TOT, have each health center team identify a training plan for training the targeted community groups (animators, TBAs, other?)
    - With project funding, health center teams train targeted community health workers in key messages.

- Increase the availability of IEC materials at the community level by:
    - Distributing those that are remaining
    - Identify and review materials already available in country through other projects of the MOH
    - Procure or replicate those that are pertinent to project activities and distribute to community workers.
- Develop a forum for CHWs to meet together and interact at the cell level (after this next training phase)
- Review additional needs for CHW motivation after the intensive project inputs of the coming 6-8 months

Activities for Strengthening the Partnership

- Review and adapt the Memorandum of Understanding since new partners are involved. Plan for devolution (equipment distribution) as part of the process.
- Immediately begin joint planning between activists and health center staff to identify and prioritize two-week work plans and to increase mutual accountability. Plans should include a plan for transporting VCT samples where needed.
- Develop a plan to make the health committees (with project financial support) responsible for working with activists and health center staff to assure health center involvement with community activities.
    - Train health committee representatives in project interventions (see first section)
    - Determine the small amount of money that will be needed on a monthly basis to provide snacks for health center staff if they are spending a full day in the field supporting community activities and give control over the planning and dispensation of this money (and accounting for how it was used?) to the health committee / activist / health center team.
- Work together at all levels on reporting and using data:

    - Generate a timely quarterly report and share it with the District management team.
    - Make sure the project HIS is consistent with that of the MOH (it was designed with this in mind)
    - Work with health center staff and activists to develop and discuss monthly report together before submitting. The health center staff meeting could provide a forum for discussing the data.
- Open a project office in Kibilizi
    - Assure the availability of power and communication (phone?)
    - Identify appropriate office space
    - Provide a computer

Intervention – Specific Actions

- Mutuelles:
    - Train trainers for mutuelle training
    - Procure standard management tools for mutuelles
    - Train mutuelle committee members in management
    - Form District confederation of mutuelles, and health and district administration to work on standardizing the plans across zones.
- Confirm with District and Province that the District health committee will remain on the back burner.
- HIV/AIDS
    - Contact MAP to determine the potential for developing MAP support for community associations such as the PVV associations – particularly in relation to income generating activities. PEPFAR may be an alternative for additional funds. (be sure to add additional staff to manage this component)
    - Meet with TRAC to assure the timely availability of quality control results and the continuous availability of testing reagents.
    - Meet with MOH/Kibilizi and the project to establish a fixed calendar for transporting quality control samples and a plan for assuring transport to meet the plan. (this involves CSP coordination with administration as well)

(Next steps for MNH, nutrition, and malaria were still to be developed)

Management

- Prioritize the presence of the activists in the field:
    - Review roles and responsibilities of different staff including the overall organogram and lines of authority in order to assure that activists are not doing any administrative activities. Make adjustments in staffing and job descriptions where necessary.

    - Make sure the supervision and support (including supplies) for activist activities are effectively covered.
    - Make sure transport policies support the maintenance of a motorcycle with every activist, and the ability of the activist to also transport a health center staff person to community activities.
    - Develop an indicator to measure whether activist presence in the field is being achieved. (e.g. after one month, the activists will be spending at least 4 days in their health center zones unless other activities are specifically included in the two week work plan)
- Establish a CSP office with a staff in Kibilizi (see above)
- Conduct an objective internal management review addressing project planning, communications and country office management systems. This review should include interviews with former staff.

ANNEX 2 – Six – Month work Plan

ACTIVITIES	*Lead*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*
BEHAVIOR CHANGE							
Identify the emphasis behaviors for each of the 4 interventions (ref DIP + field realities)	Point persons among Activists						
Collect and synthesize formative research information related to these behaviors	Point persons among Activists	Mar-29					
Develop behavior change strategies and integrate key messages and materials	Irene and BC intervention teams	Prepart ion 11 March - 5 April	12-19 April				
Review and prioritize pilot activities according to those most influential as per BC strategy	Irene		12-19 April				
Distribute existing BCC materials to Health Centers	Faustin and Samuel	X					
Identify need for specific materials and assess availability from sources (Kigali/MOH, PRIME, PSI, etc, World Relief, et Baltimore/CCP), and reproduce them.	Irene, Christophe et Michelle		X	x			
TRAINING							
Establish training team and develop modules for District Trainers linked to key messages and materials in Behavior Change Strategy (refer to FFY modules: TOT, Nutrition and HIV/AIDS)	Bonnie and Consultant		x	x	x		
Training of trainers at all levels on the above.	Bonnie et Formateurs				x	x	
Develop training action plan at Health Center level	Activists				x	x	
PARTNERSHP							
Complete an addendum to the MOU and develop action plan for disposal of materiel and equipment with Kibilizi Health District	Irene and Patrick						
Partnership Building Workshop: all CSP staff, District Health Management Team and Health Center In-Charges	Irene and Patrick	22 – 31 March					
Develop list of key project materials for the DHMT and Health Centres and make them easily available.	Madeleine		x				

ACTIVITIES	*Lead*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*
Develop agreed system for sharing data collection and analysis for the district to be shared during quarterly Titulaire meetings	Madeleine		x				
Open CSP office in Kibilizi	Christophe	15 Mars					
Training of District Trainers on Mutuelles with PRIME II	Bonnie, Pascal				X		
Cascade training on Mutuelles	Activists					x	x
Monitoring and establishment of federation of Mutuelles	Pascal					X	X
Mobilization Communautaire							
Review motivation strategies for Associations	Irene						X
Organize community actors during national and global health events (Christophe to provide annual schedule)	Activistes with Field Officer		25 April	x	x	x	X
HIV/AIDS							
Systematize transport to Kigali for tests to TRAC twice per months with	Irene						
Strenthen collaboration with TRAC to coordinate test delivery and feedback and training of VCT supervisors and counseling for new health center staff	Christophe and Patrick	23-24 Mars					
Develop proposal for add-on activities for HIV/AIDS (for MAP and/or PEPFAR)	Irene and Christophe	x	X	x			
NUTRITION							
Re-activate Community Growth Monitoring at Gikore Zone (with requested materials)	Amani		X				
Refresher nutrition training for CSP staff	Irene				x		
Integrate PD/Hearth into Gikore nutrition strategy	Amani					x	
Share Gikore PD/Hearth results	Irene					x	x
MALARIA							
Coordinate with NMCP regarding introduction of Global Fund supported long-lasting nets at subsidized prices for pregnant women, children at EPI sites, and mutuelle members	Irene and Christophe						

ACTIVITIES	*Lead*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*
Research opportunities for national subsidized nets for pregnant women and replacement with permanently treated ones (funds at HCs, Bayer, etc)	Faustin and Samuel (with support from Michelle)						
Participate in National Committee for Community Based Malaria Treatment	Irene and Faustin	x	X	x	x	x	x
Coordinate the selection of anti-malarial distributors x 5 per cellule	Field Officer with Activistes		X	x			
Training of trainers for community treatment of malaria and training of Distributers in Kibilizi	Irene, Patrick, Faustin and Samuel			x	x		
Monitor and evaluate the community malaria case management initiative	Irene, Patrick, Faustin and Samuel				x	x	x
MATERNAL & NEWBORN CARE							
Build awareness and distribute clean delivery kits.	Madeleine	Mar-29					
Conduct district situation assessment and develop strategy	Irene & Madeleine					x	
Revise TBA training curriculum AT et personnel de CS	Bonnie & Madeleine					x	x
Develop Training Curriculum for Maternal and Newborn Care for Health Facility staff	Bonnie & Madeleine					x	x
Training of Trainers for Materna land Newbron Care for Health Center staff and TBAs	Irene & Madeleine						x
Train TBAs in remaining 4 zones of project area based on revised curriculum	Madeleine						
Train health center staff in Maternal newborn care and family planning	Bonnie						
Management							
Review roles & responsibilities of each member of the CSP team	Irene	Mar-23					
Develop job descriptions and recruit for new positions of Secretary and Field Officer	Irene	Discuss JD during 22 Mar	X	x			
Assess and detail plans for establishing functional office in Kibilizi	Christophe	x					

Annex 3 – DIP Adjustments

In general, in spite of difficulties with staff turnover and the District partnership, the project is on track relative to the proposed implementation plan. They have established working relationships with their proposed target groups, have made significant progress towards the proposed training, and have the primary activities for all four interventions on the ground in pilot areas of the project.

As the project has progressed, they have been relatively less involved than projected with health center service provision. As a result, they have not done the health facilities assessment, nor have they gotten involved with continuous quality improvement. Their supervision and training activities are still quality improvement efforts.

Alternatively, as national policy has become open to the idea, the project has become involved with community-based malaria treatment, and will be implementing a pilot phase for this activity.

As a result of this evaluation, several other DIP adjustments are recommended.

1. With a revision and refocusing of the BCC strategy, the project will likely end up working with fewer community partners, and emphasizing fewer, more behaviorally oriented messages.

2. The TBA indicator proposing that "15% of TBA –assisted deliveries will be referred for complications" is difficult to measure, although it is trying to get at the key TBA behavior the project is trying to emphasize. (recognition and referral of danger signs) The project will continue to work on how to track this change as it adjusts its MNH strategy.

3. The project will be adding family planning training for providers as well as support for family planning outreach in Catholic health center zones in response to District priorities.

4. The project may be adding an activist supervisor position in the course of trying to cover administrative tasks and clarify lines of authority and responsibility.

5. Given the other priorities still facing this project, it will probably be placing less emphasis on both quality improvement and gender, although these will not be dropped.

Annex 4 - Team Members and Titles

1. Marcie Rubardt, Team Leader, Consultant
2. Dr. Jean Kagubare, Consultant, Rwanda School of Public Health
3. Kabadege Melene, Child Survival Program Coordinator, World Relief
4. Umizeye Petronile, Provincial Officer for District Coordination
5. Dr. Migambi Patrick, District Health Officer
6. Hailu Yilma, Assistant Country Director for Program, Concern
7. Dr. Irene Ndombo, CSP Project Coordinator, Concern
8. Christophe Habiyambere, Assistant Coordinator, CSP Concern
9. Bonifrida Rutijanwa, Training Offider, CSP Concern
10. Muhozali Madeleine, M&E Officer, CSP Concern
11. Lwanga Charles, Activiste, CSP Concern Kansi
12. Michelle Kouletio, Child Survival & Health Advisor, Concern US

Annex 5 - Evaluation Methodology

The evaluation involved the review of project documents, review of the survey results from the midterm Lot Quality Assessment Survey, and extensive qualitative data collection through interviews with project stakeholders, partners, and staff. Finally, these data were compiled and analyzed leading to development of conclusions and recommendations.

The evaluation process was highly participatory, involving everyone listed as a team member in all of the data collection and identification of project strengths and challenges. Once these conclusions were identified, a broader team including health center staff, all of the child survival staff, two mayors, and most of the District health Management Team worked together to develop recommendations.

The evaluation schedule was as follows:

Sun. Feb. 22	Met with Project Coordinator and National Consultant
Mon. Feb. 23	Met with Concern staff to finalize plans, Met with Concern Country Director
Tues. Feb. 24	Meeting with Kigali partners, Travelled to Butare
Wed. Feb. 25	Meeting with Kibilizi partners, Met with Provincial Medical Director, and Provincial AIDS Coordinator
Feb. 26 –28	
March 1 - 2	Field visits – 7 health centers (staff and VCT/PMTCT services), community associations (animators, TBAs, traditional healers, anti-AIDS clubs, PLWAs) mutuelle and health committees, and mothers.
Wed. March 3	Compilation of conclusions – evaluation team members
Thurs. March 4	Development of recommendations – expanded group
Fri. March 5	Definition of next steps with DHMT and project staff
Sat. March 6	Debriefed with Dr. Laurent Musango, Provincial Health Director
Mon. March 7	Finalization of results, Debriefed with Concern staff
Tues. March 8	Debriefing presentation with Kigali and Butare partners

Annex 6 – Evaluation Question Guides (English)

COMMUNITY

General Questions

1. What kinds of services are available in this area? Where do people go for pre-natal care? Delivery? Malaria treatment? Why do they go where they do?
2. What local people do you have who do health activities in this village? What do they do? Do you use their services? Why or why not?
3. What activities has the project done in this village? What activities have been most helpful or have made the most difference? How have things changed as a result of these activities?
4. What new things have you learned from the health education? How has it made a difference in what you do?
   (prompting)
   a. HIV/AIDS
   b. Malnutrition
   c. Malaria
   d. Maternal newborn health
5. Are there people in this village whom the project is not reaching? Why not?
6. What difficulties or challenges has the project faced in working in this village? Why? What has been done to alleviate them?

MNH

7. If you were pregnant, where would you deliver your baby? Why? Who would decide? Why would this person be responsible for deciding?
8. What preparations should be made for delivery? Did you or would you do these? Why or why not?
9. What are important things to do to take care of you and your baby When you are pregnant? After the baby is born? What are sign you should go to the health center when you are pregnant? For your newborn?
10. Would you like to be tested for HIV if you were pregnant? Why or why not? What are the benefits to knowing your HIV status when you are pregnant? Do you know anyone who is HIV positive who received treatment for the baby when they were pregnant? What was their experience?
11. Did you or anyone you know buy a bednet? Who sleeps under them?
12. *specific knowledge and behaviors?)*

HIV/AIDS

13. Have you or anyone you know been tested for HIV? What was their experience? How has the test affected your / their life?
14. Do you know of people living with AIDS in this village? What things can be done to help make their lives more positive?

Growth Monitoring

15. *Are you aware of children that are underweight in this village? Are there children who are not underweight in this village? How is the care of the underweight children different from that for those who are not underweight*? How should children who are underweight be treated so they can get better?

QUESTION GUIDES – COMMUNITY VOLUNTEERS

(TBAs, Traditional Healers, Community Health Workers, PLWHAs)

1. What do you do as a community health volunteer?
2. What training did you have to improve your skills?
3. Who monitors or supports your activities? When was the last time you discussed your activities with someone from the project or the health center? Who was it? What did you discuss? What, if anything, are you doing differently as a result of that discussion?
4. How have your activities changed since the beginning of the project?
5. How have the practices of people in your village changed since the beginning of the project?
6. How do you link with other community health volunteers? With health center staff? With project staff?
7. What kind of health information do you collect? What do you do with it? What does it tell you?

Specific technical information (*specific knowledge and behaviors?)*

8. TBAs – Do they know/practice danger signs, clean delivery (6 cleans), referral, newborn care (immediate breast feeding, cord care, clean razor blade for cutting, no bathing, etc.
9. HIV/AIDS – Do they know indications for testing, treatment, referral. How do they identify and involve people who have AIDS to live positively? Advocacy?
10. Malaria – is there community treatment? What protocols? Sale of bednets? Referral?
11. Nutrition – process for growth monitoring, identifying messages for counseling, referral, implementation of Hearth

QUESTION GUIDE – DHMT

1. What are the biggest strengths and accomplishments since the project started? Why?
2. What have been some of the biggest constraints or challenges since the project started? Why? What has been done to address them?
3. What are some of the biggest remaining weaknesses that need to be addressed during the remainder of the project. Why? What suggestions do you have for addressing them?
4. How was the DHMT involved with planning this project? Has it gone as you had hoped? Why or why not? What would you do differently?
5. What is your responsibility for supporting the COSAs? The mutuelles? How is it going? How has the project assisted with this support?
6. How has the project been involved with strengthening the district management systems? (supervision, logistics, training, planning, transport, M&E, finance management, etc.) Has this been helpful? Are there things they should or should not be doing? What kinds of assessment was done initially to determine priorities and were the indications followed? (Why or why not?) (*there have been problems with VCT reagents*?)
7. How is the DHMT generation and use of data changed as a result of the project? How are the data generated by the project being used?
8. What strategies and approaches for behavior change are being used in the district? Are the project approaches consistent with others? Are they effective? Why or why not?
9. How is the district involved with improving the quality of health services. What is the role of the project in these interventions?
10. What plans have been made for devolution at the end of the project? (continuation of activities, COSAs, mutuelles, supervision, training, etc.)

<u>Specific technical issues</u>

11. HIV/AIDS - What is the current district policy and strategy for PMTCT and VCT? What are the constraints? How is the project helping?
12. MNH - What is the current district policy and strategy for maternal and newborn care? What are the constraints? How is the project helping?
13. How does the Hearth approach to malnutrition fit in with other district activities?
14. Malaria - What is the policy on community based treatment for malaria? Is the project approach consistent? How might this be encouraged? What is the plan for sustaining bednet distribution?

QUESTION GUIDE – HEALTH FACILITY STAFF

1. What kinds of services are available in this area? Where do people go for pre-natal care? Delivery? Malaria treatment? Why do they go where they do?

2. What have been the main activities of the project in this area? Which have been most helpful or made the most difference? Why? How have things changed as a result of these activities?

3. What support has the project offered the health center? Training? Supervision? Equipment? How has the health center staff been involved with determining what the project is doing and how it is done?
4. What has been most helpful?

5. What are the biggest difficulties or challenges the project has faced and why? What has been done to alleviate them? What are the biggest current weaknesses?

6. Are there people whom the project is not reaching? Why not? What could be done to improve their access?

7. What kinds of quality improvement activities are being carried out in this health center? How are they making a difference?

8. What information do you collect? What does it tell you? What difference does it make?

9. What is your relationship with community health workers? How often do you see them? What do you discuss? What difficulties do they face and how do you help them?

10. *How have your attitudes towards men's and women's roles and responsibilities changed as a result of project activities? What made the most difference?I*

    Specific Technical Information (*specific knowledge and behaviors?)*

11. Malaria: Case management protocol, management of bednet sales, need for referral

12. HIV/AIDS – what counseling, blood draw / referral for testing, living positively, nevirapine treatment, PMTCT, STI diagnosis and treatment (partner identification?)

13. Malnutrition – case management, consideration of underlying illness, Hearth
|
14. MNH – referral for VCT, PMTCT, essential newborn care, danger signs and referral,

QUESTION GUIDE – NATIONAL LEVEL PARTNERS

1. What are the biggest strengths and accomplishments since the project started? Why?

2. What have been some of the biggest constraints or challenges since the project started? Why? What has been done to address them?

3. What are some of the biggest remaining weaknesses that need to be addressed during the remainder of the project. Why? What suggestions do you have for addressing them?

4. How were national partners involved with planning this project? Has it gone as you had hoped? Why or why not? What would you do differently?

5. How has the project been involved with strengthening the district management systems? (supervision, logistics, training, planning, transport, M&E, finance management, etc.) Has this been helpful? Are there things they should or should not be doing? What kinds of assessment was done initially to determine priorities and were the indications followed? (Why or why not?

6. How are project data being used to strengthen health activities? Are they appropriate without being excessive?

7. What strategies and approaches for behavior change are being used by the project? Are the project approaches consistent with others? Are they effective? Why or why not?

8. How is the project involved with improving the quality of health services. Is it consistent with national efforts?

9. What plans have been made for devolution at the end of the project? (continuation of activities, COSAs, mutuelles, supervision, training, etc.)

<u>Specific technical issues</u>

10. HIV/AIDS - What is the current policy and strategy for PMTCT and VCT? What are the constraints? How is the project helping?
11. MNH - What is the current policy and strategy for maternal and newborn care? What are the constraints? How is the project helping?
12. How does the Hearth approach to malnutrition fit in with other nutrition activities?
13. Malaria - What is the policy on community based treatment for malaria? Is the project approach consistent? How might this be encouraged? What is the plan for sustaining bednet distribution?

QUESTION GUIDE – CONCERN STAFF

1. What are the biggest strengths and accomplishments since the project started? Why?

2. What have been some of the biggest constraints or challenges since the project started? Why? What has been done to address them?

3. What are some of the biggest remaining weaknesses that need to be addressed during the remainder of the project. Why? What suggestions do you have for addressing them?

4. What are the specific roles and responsibilities of different project staff with respect to project activities? Is the division of responsibilities working? How might it work better? Is the staffing level adequate and the work load manageable?

5. What has been done for staff development? What should be?

6. How does support happen within the organization (supervision, logistics and procurement, financial management)? Is it adequate? Why or why not?

7. How well does the organization support data management? Are the data easily accessible and useable? Why or why not?

8. What TA has been most helpful? Why? Least helpful? Why? (TASO visit, Michele, Hearth, other?) What additional TA is needed?

9. How are information and lessons learned shared within Rwanda staff? Internationally within the agency?

Annex 7 - List of Persons Interviewed / Documents Reviewed

PEOPLE CONTACTED

Kigali – Preliminary Meeting

1. Dr. Bikorimana Ferdinand, Reproductive Health Division, MOH
2. Keita Bintou, Country Representative, UNICEF
3. Dr. Kimanuka Francine, UNICEF
4. Dr. Kashala Jean Pierre, Healthnet Butare
5. Rachel Kapirwa, Nutrition Division, MOH
6. Kabadege Melene, Child Survival Program, World Relief
7. Rebecca Chandler, Director, World Relief Rwanda
8. Muhozali Madeleine, M&E Officer, CSP Concern
9. Hailu Yilma, Assistant Country Director for Program, Concern
10. Bonifrida Rutijanwa, Training Offider, CSP Concern
11. Christophe Habiyambere, Assistant Coordinator, CSP Concern
12. Dr. Irene Ndombo, CSP Project Coordinator, Concern

Butare – Preliminary Meeting

1. Mumyantore Baptiste, Kansi Health Center
2. Dr. Migambi Patrick, District Medical Officer, Kibilizi
3. Erudina Catafair, Titulaire, Gikore
4. Mutangoha Usabase Fidele, Titulaire, Kibilizi
5. Mukabayiro Brigitte, Titulaire, Kirarambogo
6. Mukashyaka Immaculee, Secretary, Kibilizi District MOH
7. Rekeraho, Jean, MOH Supervisor, Kibilizi
8. Semacumi John, Titulaire, Kigembe
9. Nibazungu Marie Josee, COSA Kibilizi
10. Epiphanie Mukabaranga, Titulaire, Kansi
11. Nyongana Theogene, Titualire, Kibayi
12. Samuel Ndansamiyumikazo, Activiste, CSP Concern
13. Lwanga Charles, Activiste, CSP Concern Kansi
14. Bukanda Amani, Activiste, CSP Concern, Gikore
15. Nkuru Pascal, Activiste, CSP Concern, Kigembe
16. Gakera Leonard, Activiste, CSP Concern, Kirarambogo
17. Rwakazina Faustin, Activiste, CSP Concern, Kibilizi
18. Matoto Elis, Activiste, CSP Concern, Mugombwa
19. Muhozali Madeleine, M&E Officer, CSP Concern
20. Hailu Yilma, Assistant Country Director for Program, Concern
21. Bonifrida Rutijanwa, Training Offider, CSP Concern
22. Christophe Habiyambere, Assistant Coordinator, CSP Concern
23. Dr. Irene Ndombo, CSP Project Coordinator, Concern

Butare Province

1. Dr. Laurent Musango, Provincial health Director
2. Umizeye Petronille, Provincial Officer for District Coordination
3. Ayingoma Jean-Pierre, Provincial AIDS Officer

District Management Team

1. Dr. Migambi Patrick, District Health Officer
2. Rekeraho Jean, MOH Supervisor, Kibilizi
3. Mukashyaka Immaculee, Secretary, Kibilizi District MOH
4. Nzibaliza Naphtali, Administrator, Kibilizi District
5. District Pharmacist

Concern Senior Staff

1. Eddie Rogers, Country Director
2. John Minto, Assistant Country Director - Administration
3. Hailu Yilma, Assistant Country Director - Programmes
4. Roman Oser, Field Accountant
5. Justin Biragane, Programmes Manager

Field Visits

Kansi Health Center

1. Titulaire
2. Service visits – PMTCT, VCT,
3. PVV Association
4. Anti-AIDS club
5. Trained primary school teachers
6. Health Animator Association
7. Association of TBAs
8. Recently delivered mothers

Kibilizi Health Center

1. Service VCT
2. Trained primary school teachers
3. Anti-AIDS club

Gikore Health Center

1. Health Center Staff
2. Health Animator Association
3. Association of TBAs – (Trained and Untrained)
4. Association Traditional Healers

Mugombwa Health Center

1. Health center staff
2. TBAs Association – Trained & Untrained
3. Health Animators Association
4. PVV Association
5. Anti-AIDS club
6. Trained primary teachers
7. Recently delivered mothers

Kibayi Health Center

1. Health center staff
2. traditional healers
3. Association of TBAs
4. health animators group
5. Recently delivered mothers

Kigembe Health Center

1. Health center staff
2. Health animators association
3. Association of Traditional healers
4. Association of Untrained TBAs
5. Recently delivered mothers
6. Health committee
7. Mutuelle committee

Kirarambogo Health Center

1. Health center staff
2. Health committee
3. Mutuelle committee

Kibingo Administrative District

1. Mayor
2. Administrative Secretary

Mugombwa Administrative District

1. Mayor
2. Vice – mayors
3. District inspector
4. Administrative Secretary
5. Community development committee
6. Administrative sector advisors

DOCUMENTS REVIEWED

Project Reports

1. USAID Concern Rwanda - Kibilizi District Health Partnhership, 5 Year Detailed Implementation Plan , 3/02.
2. USAID Concern Rwanda - Kibilizi District Health Partnhership, Knowledge, Practice and Coverage Baseline Survey, 3/02
3. USAID Concern Rwanda - Kibilizi District Health Partnhership, First Annual Report, 1/02
4. USAID Concern Rwanda - Kibilizi District Health Partnhership, Gender and Health Study Overview, 8/02.
5. USAID Concern Rwanda - Kibilizi District Health Partnhership, Second Annual Report3/03

Other Project Documents

1. Dr. Sibomana Jean Claude, « Module de Formation des Accoucheuses Traditionnelles dans le District Sanitaire de Kibirizi », 3/03.
2. Rapport du Seminaire Atelier sur le VIH/SIDS et Genre, 11/03
3. Misc. other training reports
4. ISA Report, June 2003
5. Comparing Results – annex comparing ISA 2001 results to those of 2003.

Other documents

1. Core Sustainability Initiative Training Materials
2. Sustainability Review of a Model for Municipal Health in Bangladesh, 17-23 Feb. 2003.

Annex 8 – Review of Technical Assistance Visits

Summary of Field Support Visits by Technical Backstop from June 2002 – March 2004

Date of Visit	Major Tasks	Major issues arising during visit
June 2002	Orientation to Programme Visit to 5 HC areas and meeting with A/S, TBAs, and PVV group (Kansi) Discuss and plan based on DIP feedback with team Cross-Visit to Nemba District Health programme (community nutrition and traditional healers)	Getting beyond working at the health centre with community groups Support district with detection and confirmation of Meningitis outbreak Difficulty getting m/cycle licenses for staff Availability of small grants for local groups in conjunction with CDCs Need to establish M&E system and update logframe Raised issue about disparity between nat'l SMI policy and international standards Concerns by District about transportation vs. m/cycles to HCs
October 2002	Guide team in development of 1st Annual Report Analyse staffing situation Review and update M&E plan Initial review of gender & health study Stakeholder meeting to reach concensus on district ambulance Visit Mugombwa HC and PVV and anti-AIDS clubs Co-facilitate LQAS training in Kibungo	Updated JDs including work locations Agreed on technical focus roles for all staff Agreed on establishment of Kibilizi office Steps to ensure completion of gender & health study analysis from School of Public Health Agreement for vehicle contribution to District
April 2003	Complete M&E plan Preparation for safe delivery kits and community nutrition components Orientation to BEHAVE framework and development of mosquito net strategy Observe TBA training Meet with national actors on policies for malaria and safe motherhood initiative (PRIME II, PSI, PNLP)	Need to update TBA curriculum to refocus on birth preparedness, referral/danger signs, and postpartum and newborn care Suggested to consider PD/Hearth approach into community nutrition and ensure availability of micronutrient supplements and de-worming medicine
August 2003	Review and develop 2nd annual report with team Administrative and technical support to Acting Coordinator Field review of PNBC Field review of TBAs LQAS preparation	Issues raised about working locations, shifted away from Kibilizi office LQAS team set schedule for developing questionnaire and tabulation tools Preparation for new Coordinator Observations of involving staff in administration and logistics
March 2004	Midterm Evaluation Orientation of New Coordinator Review HMIS with new District Medical Officer Action planning and office move preparation with CSP staff	Immediate need to review BCC strategy and training strategy Restructure management plan to support Activists/field activities Preparation to revise nutrition and SMI strategies

Annex 9 - Review of Quantitative Data Against Objectives (LQAS and HIS)

Indicators	Baseline/ Year 1	Year 2 Target	End of Project Target	HIS Oct 02-Sept 03	LQAS Jan 04
Impact Indicators					
Reduced child mortality rate in Kibilizi District to below 100 per 1,000 live births	127.7 (DHS Butare 2000)		<100	Child deaths FOSA: 76 Community: 122	Not measured
Reduced frequency of events of maternal deaths that took place in the community over time			Less than 50%	Maternal deaths HC: 1 Community: 8	Not measured
Reduced underweight (-2SD) children aged 0-23 months from 58.7% to 45.0%	58.7%	55%	45.0%	CGMP in Gikore 85% (n=122)	W/A Malnutrition 12-23 months 38%
Effect Indicators					
Increased by 50% STD consultations from baseline (HIS 2001)	134	154	201	STDs = 298 Mostly Kibayi, Kigembe & Mugombwa	Not measured
Increased from 10 to 20% of adults who have received VCT services.	10%	12%	20%	VCT Fe - 780 PMTCT Fe-749 (Women 4%) VCT Male - 774 (Men 2%)	 Men 26% (DSK 11%) Women 19% (DSK 9%)
At least 50% of antenatal women at Kansi HC participate in PMTCT	0%	50%	50%	749 Fe acceptant / 830 CPN a Kansi (90% acceptant)	Not in LQAS but 28% know about PMTCT and 16% participated
Increased proportion of at seropostive pregnancies protected with appropriate administration of niverapine (per TRAC guidelines)	0%	40%	40%	Oct 02-Jan 04 Femme 34 Enfants 11 (32%)	Not in LQAS
Increased the proportion of children age 0-23 months who were breastfed in first hour after delivery from 38% to 50%.	38%	42%	50%	N/A	56%
Increased the proportion of children aged 0-23 months who slept under a treated mosquito net last night from 0.9% to 10%.	0.9%	5%	10%		0-11 years 34% 12-23 years 5%
Proportion of women with children < 24 months with at least 2 doses of TT from 23.8% to 40%.	23.8%	28%	40%	?	68%
Increase the proportion of TBA clients referred to 15% due to complications.		15%	15%	98 referred and 185 home deliveries (35% of all TBA deliveries transferred)	30% of deliveries by TBA

Indicators	Baseline/ Year 1	Year 2 Target	End of Project Target	HIS Oct 02-Sept 03	LQAS Jan 04
Increased proportion of all deliveries that place at a health institution from 15% to 35%.	15%	20%	35%	HIS 1178/7045 = 17%	28% (delivered with muganga)
Capacity Indicators District Health Team will demonstrate a measurable improvement in selected capacity areas prioritized during the baseline HICAP					
PROCESS OUTPUTS					
Quality annual district health plan with clear financing plan based on data (HIS, community)		1	1		
Increased to 7 the number of health facilities with functional COSAS (independently operational, and making bimonthly workplans)	7	7	7		
Participatory monthly District Health Team meetings revolving among health centers with documented minutes and follow-up			12		
At least 65% of VCT pre and post consultations that meet minimum quality standards		50%	65%		
At least 75% of malaria consultations that meet minimum quality standards			75%		
At least 65% of children 0-36 months underweight who were counseled and referred appropriately			65%		
At least 65% of health staff able / detect underlying illness(es) of malnourished children			65%		
At least 60% of trained TBAs who accurately recognize danger signs and minimum conditions needed for hygienic deliveries			60%		
At least 65% of trained people assisting deliveries that provide minimum standard of care for newborns			65%		
At least 21 cellules with functional Community-GM program (at least 50% of children < 36 months participating)		3	21		
At least one functional VCT site available in the district		1	1		
At least three mutuelles are providing health insurance services at Health Centers with a participation of > 30% of eligible households		2	3		
At least 70% of health centers actively engaging associations of traditional practitioners, TBAs, A/S, and PLWHAs			70%		
At least 80% of A/S who are actively working in the community and reporting monthly.			80%		
Transformation change in attitude of men and women on 1-2 agreed gender issues emerging from Gender and Health Study					
Increased understanding of gender and child rights among district administration and health authorities in Kibilizi					

Indicators	**Baseline/ Year 1**	**Year 2 Target**	**End of Project Target**	**HIS Oct 02-Sept 03**	**LQAS Jan 04**
Increased proportion of adults aged 15-49 who correctly identify at least two known ways to reduce risk of transmission of HIV/AIDS from 24% to 80%.	Women 24%	35%	80%	Not in HIS	Men - 90% Women – 74%
Increased proportion of adults aged 15-49 who correctly identify at least two danger signs of severe malaria to 50%.			50%		Men – 20% Women – 17%
Increased proportion of adults aged 15-49 who know that Vitamin A reduces risk of mortality in the child to 60%			60%		Men – 17% Women – 16%
Increased proportion of adults aged 15-49 who correctly identify danger signs of malnutrition and appropriate actions for care to 60%.			60%		Men – 47% Women – 52%
Increased proportion of adults aged 15-49 who correctly identify at least two maternal danger signs for the following periods: 1) antepartum, 2) intrapartum; 3) postpartum and 4) newborn to 60%.		30%	60%		<u>Pregnancy</u> Men 35% Women 50% <u>Delivery</u> Men 26% Women 46% <u>Postpartum</u> Men 36% Women 37% <u>Newborn</u> Men 17% Women 31%
Documented trimester CSP meetings where staff review, analyze and plan future activities		1	3		
Increased technical competency level of CSP staff in the areas of HIV/AIDS, malaria, nutrition and maternal and newborn care					
Increased quality of performance objectives established and achieved by CSP staff					

Annex 10 - LQAS Report

CHILD SURVIVAL PROGRAM

MATERNAL & CHILD HEATLH SURVEY USING LOT QUALITY ASSURANCE SAMPLING

Period: 19 - 30 January 2004

Kibilizi Health District, Rwanda

SUMMARY TABLES REPORT

Prepared and Presented by : Dr NDOMBO Irène Elisabeth, CSP Coordinator
HABIYAMBERE Christophe, Assistant CSP Coordinator
RUTIJUWANA Bonifrida, Capacity Building Officer

February 24, 2004 at Kigali, Rwanda

SUMMARY TABLE -CSP KIBILIZI === MALE ADULTS

Health District:--------KIBILIZI---------/BUTARE-/ RWANDA ---------- Date:…30 January 2004……..

#	Indicator	Total Correct per zone / Decision Rule							Total Correct in zone	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	FAMILY PLANNING																	
6	Know at least 2 modern family planning methods	9	13	6	12	16	13	14	83	19	19	19	19	19	19	19	133	**62%**
		10	10	10	10	10	10	10										
	COUPLE COMMUNICATION FOR HEALTH																	
11	Men who report talking to wife about the health of the child	18	17	10	11	18	18	14	106	19	19	18	13	19	19	19	126	**84%**
		14	14	13	10	14	14	14										
	STDs/HIV/AIDS																	
13	Heard of HIV/AIDS	19	17	18	14	19	18	19	124	19	19	19	19	19	19	19	133	**93%**
		16	16	16	16	16	16	16										
15	Know at least 2 ways to protect oneself from HIV	16	14	9	16	16	17	18	106	19	19	19	19	19	19	19	133	**80%**
		13	13	13	13	13	13	13										
17	Has been tested for HIV/AIDS / participated in VCT	2	5	4	3	6	5	7	32	19	17	18	14	19	18	19	124	**26%**
		3	2	2	2	3	2	3										
18	Received VCT services in Kibilizi District	2	1	2	0	1	5	3	14	19	19	19	19	19	19	19	133	**11%**
		NA	NA	NA	NA	NA	NA	NA										
19	Of those tested, satisfied with VCT	2	5	4	3	6	5	6	31	2	5	4	3	6	5	7	32	**97%**

SUMMARY TABLE -CSP KIBILIZI === MALE ADULTS

Health District:--------KIBILIZI---------/BUTARE-/ RWANDA ---------- Date:…30 January 2004……..

#	Indicator	Total Correct per zone / Decision Rule							Total Correct in zone	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	service	NA	NA	NA	NA	NA	NA	NA										
20	Men thinking about being tested in the next year.	15	17	10	9	7	15	13	86	19	19	19	19	16	19	19	133	65%
		10	10	10	10	10	10	10										
21	Men willing to provide support to PLWHAs	8	7	10	15	14	15	14	83	19	19	19	19	19	19	19	133	62%
		10	10	10	10	10	10	10										
22	Has heard of STDs	16	17	15	12	16	18	19	113	19	18	19	14	19	19	19	127	89%
		15	14	15	11	15	15	15										
23	Know at least 2 signs or symptoms of STDs	5	10	6	6	12	16	8	63	19	19	19	19	19	19	19	133	47%
		7	7	7	7	7	7	7										
	MALARIA																	
24	Know that there is malaria in the district	19	19	19	14	19	19	19	128	19	19	19	14	19	19	19	128	100%
		NA	NA	NA	NA	NA	NA	NA										
25	Know at least 2 signs of severe malaria	0	8	4	0	9	4	2	27	19	19	19	19	19	19	19	133	20%
		2	2	2	2	2	2	2										
26	Know at least one way of preventing malaria	14	19	14	11	16	19	17	110	19	19	19	14	19	19	19	128	86%
		14	14	14	11	19	19	19										
27	Know that pregnant women and	11	10	7	3	11	15	13	70	19	19	19	14	19	19	19	128	55%

SUMMARY TABLE -CSP KIBILIZI === MALE ADULTS

Health District:--------KIBILIZI---------/BUTARE-/ RWANDA ---------- Date:…30 January 2004……..

#	Indicator	Total Correct per zone / Decision Rule							Total Correct in zone	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	young children are most vulnerable to malaria	8	8	8	11	8	8	8										
	MATERNAL AND NEWBORN CARE																	
28	Know at least 2 danger signs during pregnancy	4	6	3	7	5	12	10	47	19	19	19	19	19	19	19	133	**35%**
		5	5	5	5	5	5	5										
29	Know at least 2 danger signs during delivery	6	2	1	6	5	8	7	35	19	19	19	19	19	19	19	133	**26%**
		3	3	3	3	3	3	3										
30	Know at least 2 danger signs during post-partum period	9	7	2	3	8	11	8	48	19	19	19	19	19	19	19	133	**36%**
		5	5	5	5	5	5	5										
31	Know at least 2 danger signs for newborn	3	0	4	1	4	2	9	23	19	19	19	19	19	19	19	133	**17%**
		1	1	1	1	1	1	1										
	NUTRITION																	
32	Heard of Vitamin A	11	10	7	6	12	11	10	67	19	19	19	14	19	19	19	128	**52%**
		8	8	8	11	8	8	8										
34	Know importance of Vitamin A	5	2	2	2	4	6	2	23	19	19	19	19	19	19	19	133	**17%**
		1	1	1	1	1	1	1										
35	Know at least 2 signs of child malnutrition	2	7	6	11	5	16	15	62	19	19	19	19	19	19	19	133	**47%**
		7	7	7	7	7	7	7										
36	Know the three food groups	14	18	5	9	12	10	10	78	19	19	19	19	19	19	19	133	**59%**

SUMMARY TABLE -CSP KIBILIZI === MALE ADULTS

Health District:--------KIBILIZI---------/BUTARE-/ RWANDA ---------- Date:…30 January 2004……..

#	Indicator	Total Correct per zone / Decision Rule							Total Correct in zone	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
		9	9	9	9	9	9	9										

SUMMARY TABLE -CSP KIBILIZI===FEMALE ADULTS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	Indicator	Total Correct by Zone / Decision Rule							TOTAL CORRECT	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	FAMILY PLANNING																	
4	Have heard about Family Planning	16	15	17	17	17	12	19	113	19	19	19	19	19	19	19	133	**85%**
		14	14	14	14	14	14	14										
5	Know at least one method of family planning	10	13	13	13	15	9	17	90	19	19	19	19	19	19	19	133	**68%**
		11	11	11	11	11	11	11										
6	Know at least 2 modern methods	7	13	8	12	13	6	12	71	19	19	19	19	19	19	19	133	**53%**
		8	8	8	8	8	8	8										

SUMMARY TABLE -CSP KIBILIZI===FEMALE ADULTS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	**Average Coverage=*Total Correct / Sample Size***
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
7	Use family planning now	5	3	1	4	2	2	6	23	19	19	19	19	19	19	19	133	**17%**
		1	1	1	1	1	1	1										
8	Using a modern method	5	2	1	4	2	2	6	22	19	19	19	19	19	19	19	133	**17%**
		1	1	1	1	1	1	1										
9	Couples using family planning who decided together	4	3	0	3	2	1	6	19	5	3	1	4	2	2	6	23	**83%**
		NA	NA	NA	NA	NA	NA	NA										
	COUPLE COMMUNICATION																	
11	Women who report talking to husband about the health of the child	12	9	10	13	9	9	14	76	18	18	16	16	17	19	19	123	**62%**
		10	10	9	9	9	10	10										
	MST/VIH-SIDA																	
13	Heard of HIV/AIDS	16	18	16	19	19	18	19	125	19	19	19	19	19	19	19	133	**94%**
15	Know at least 2 ways to protect oneself from HIV	12	16	7	18	15	12	18	98	19	19	19	19	19	19	19	133	**74%**
		12	12	12	12	12	12	12										
17	Has been tested for HIV/AIDS / participated in VCT	2	7	1	4	4	3	3	24	16	19	16	19	19	19	19	127	**19%**
		1	1	1	1	1	1	1										
18	Received VCT services in Kibilizi	0	6	0	0	2	3	1	12	19	19	19	19	19	19	19	133	**9%**

SUMMARY TABLE -CSP KIBILIZI===FEMALE ADULTS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	Indicator	Total Correct by Zone / Decision Rule							TOTAL CORRECT	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	District	NA	NA	NA	NA	NA	NA	NA										
19	Of those tested, satisfied with VCT service	2	4	1	4	4	3	3	21	2	7	1	4	4	3	3	24	**88%**
		NA	NA	NA	NA	NA	NA	NA										
20	Thinking about being tested in the next year.	13	17	7	11	6	10	12	76	19	19	19	19	18	19	19	132	**58%**
		9	9	9	9	9	9	9										
21	Willing to provide support to PLWHAs	9	11	11	17	14	10	10	82	19	19	19	19	19	19	19	133	**62%**
		10	10	10	10	10	10	10										
22	Ever heard of STDs	15	17	15	18	17	15	17	114	19	19	19	19	19	19	19	133	**86%**
		15	15	15	15	15	15	15										
23	Know at least 2 signs or symptoms of STDs	3	3	7	9	5	7	6	40	19	19	19	19	19	19	19	133	**30%**
		3	3	3	3	3	3	3										
	MALARIA																	
24	Know that there is malaria in the district	19	19	19	19	18	19	19	132	19	19	19	19	19	19	19	133	**99%**
		NA	NA	NA	NA	NA	NA	NA										
25	Know at least 2 signs of severe malaria	1	3	1	2	7	4	4	22	19	19	19	19	19	19	19	133	**17%**
		1	1	1	1	1	1	1										
26	Know at least one way of	15	14	19	17	14	14	13	106	19	19	19	19	19	19	19	133	**80%**

SUMMARY TABLE -CSP KIBILIZI===FEMALE ADULTS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	Indicator	Total Correct by Zone / Decision Rule							TOTAL CORRECT	Sample Size by Zone							Total Sample Size	Average Coverage=Total Correct / Sample Size
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
	preventing malaria	13	13	13	13	13	13	13										
27	Know that pregnant women and young children are most vulnerable to malaria	5	8	1	3	6	7	5	35	19	19	19	19	19	19	19	133	**26%**
		3	3	3	3	3	3	3										
	MATERNAL AND NEWBORN CARE																	
28	Know at least 2 danger signs during pregnancy	6	15	6	7	9	13	11	67	19	19	19	19	19	19	19	133	**50%**
		8	8	8	8	8	8	8										
29	Know at least 2 danger signs during delivery	6	7	4	13	9	9	13	61	19	19	19	19	19	19	19	133	**46%**
		7	7	7	7	7	7	7										
30	Know at least 2 danger signs during post-partum period	4	9	4	8	7	10	7	49	19	19	19	19	19	19	19	133	**37%**
		5	5	5	5	5	5	5										
31	Know at least 2 danger signs for newborn	1	3	5	9	10	7	6	41	19	19	19	19	19	19	19	133	**31%**
		4	4	4	4	4	4	4										
37	Mothers who know danger signs of child with fever	1	12	0	5	6	5	12	41	19	18	19	18	19	19	19	131	**31%**
		4	3	4	4	4	4	4										
	NUTRITION																	
32	Heard of Vitamin A	12	14	11	11	13	11	15		19	19	19	19	19	19	19		
		11	11	11	11	11	11	11	87								133	**65%**
34	Know importance of Vitamin A	1	11	0	0	3	4	2	21	19	19	19	19	19	19	19	133	**16%**

SUMMARY TABLE -CSP KIBILIZI===FEMALE ADULTS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	**Average Coverage=*Total Correct / Sample Size***
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
		1	1	1	1	1	1	1										
35	Know at least 2 signs of child malnutrition	2	13	8	10	8	13	15		19	19	19	19	19	19	19		
		8	8	8	8	8	8	8	69								133	**52%**
36	Know the three food groups	14	19	9	9	16	12	16		19	19	19	19	19	19	19		
		12	12	12	12	12	12	12	95								133	**71%**
38	Meres connaissant quand il faut amener l'enfant dans une formation sanitaire	16	17	16	17	18	15	19		19	18	19	19	19	19	19		
		15	14	15	15	15	15	15	118								132	**89%**

SUMMARY TABLE -CSP KIBILIZI===MOTHERS OF CHILDREN AGED 12-23 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	Indicator	Total Correct by Zone / Decision Rule							TOTAL CORRECT	Sample Size by Zone							Total Sample Size d'Echantillon dans le Programme	Average Coverage=Total Correct / Sample Size / Taille d'Echantillon
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kiraramb ogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kiraramb ogo	Mugombwa		
									MALARIA									
4	Heard of a mosquito net	19	13	19	15	13	19	17	115	19	19	19	19	19	19	19	133	**86%**
		15	15	15	15	15	15	15										
5	Owns a mosquito net	1	3	5	2	0	4	4	19	19	19	19	19	19	19	19	133	**14%**
		NA	NA	NA	NA	NA	NA	NA										
6	Child slept under net last night	1	0	5	1	0	4	0	11	19	19	19	19	19	19	19	133	**8%**
		NA	NA	NA	NA	NA	NA	NA										
7	Child slept under TREATED net last night	1	0	2	0	0	2	2	7	19	19	19	19	19	19	19	133	**5%**
		NA	NA	NA	NA	NA	NA	NA										
9	Mother slept under TREATED net last night	1	0	2	0	0	2	2	7	19	19	19	19	19	19	19	133	**5%**
		NA	NA	NA	NA	NA	NA	NA										
11	Child sick with fever in past two weeks	11	14	7	7	8	9	12	68	19	19	19	19	19	19	19	133	**51%**
		8	8	8	8	8	8	8										
12	Sick child with fever treated at health center	7	4	5	2	5	2	5	30	11	14	7	7	8	9	12	68	**44%**
		NA	4	NA	NA	NA	NA	NA										
13	Sick child with fever treated at	2	1	2	1	1	1	1	9	11	14	7	7	8	9	12	68	**13%**

SUMMARY TABLE -CSP KIBILIZI===MOTHERS OF CHILDREN AGED 12-23 MONTHS																				
Health District:------KIBILIZI---/BUTARE----------																			Date:…30 January 2004…	
#	***Indicator***	***Total Correct by Zone / Decision Rule***							***TOTAL CORRECT***	***Sample Size by Zone***							***Total Sample Size d'Echantillon dans le Programme***	**Average Coverage=*Total Correct / Sample Size* / *Taille d'Echantillon***
		Gikore	**Kansi**	**Kibayi**	**Kibilizi**	**Kigembe**	**Kirarambogo**	**Mugombwa**		**Gikore**	**Kansi**	**Kibayi**	**Kibilizi**	**Kigembe**	**Kirarambogo**	**Mugombwa**		
	health center within 24 hours of symptoms	NA	NA	NA	NA	NA	NA	NA										
14	Child weighed at least once in past 3 months	7	6	1	9	8	8	4	43	19	19	19	19	19	19	19	133	**32%**
		4	4	4	4	4	4	4										
15	Child weighed 3 times in past 3 months	6	9	1	3	9	9	2	39	19	19	19	19	19	19	19	133	**29%**
		3	3	3	3	3	3	3										
19	Child ever received Vitamin A supplement	16	17	16	17	18	18	18	120	19	19	19	18	19	19	19	132	**91%**
		16	16	16	16	16	16	16										
20	Child received Vitamin A supplement within past six months	17	17	17	18	16	17	16	118	19	19	18	19	19	19	19	132	**89%**
		15	15	14	15	15	15	15										
22	Child receiving breastmilk and foods	18	17	19	19	19	17	17	126	19	19	19	19	19	19	19	133	**95%**
		16	16	16	16	16	16	16										
23	Child weaned at 6 months	14	7	9	6	14	5	7	62	19	19	19	19	19	19	19	133	**47%**
		7	7	7	7	7	7	7										
24	Child received at least one food from each of the three food groups yesterday	11	10	2	6	5	10	6	50	19	19	19	19	19	19	19	133	**38%**
		5	5	5	5	5	5	5										
25	Mother know the 3 food groups	9	18	6	18	16	7	12	86	18	19	18	19	19	19	19	131	**66%**

SUMMARY TABLE -CSP KIBILIZI===MOTHERS OF CHILDREN AGED 12-23 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	Indicator	Total Correct by Zone / Decision Rule							TOTAL CORRECT	Sample Size by Zone							Total Sample Size d'Echantillon dans le Programme	Average Coverage=Total Correct / Sample Size / Taille d'Echantillon
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
		11	11	11	11	11	11	11										
31	Child underweight (W/A<-2 Z score)	7	6	7	7	9	6	9	51	19	19	19	19	19	19	19	133	38%
		5	5	5	5	5	5	5										
26	Child fully vaccinated by age of 12 months (reported by mother)	15	17	19	19	18	16	17	121	19	19	19	19	19	19	19	133	91%
		16	16	16	16	16	16	16										
28	Child fully vaccinated by age of 12 months (verified by card)	14	18	16	15	13	5	15	96	19	19	19	19	19	19	19	133	73%
		12	12	12	12	12	12	12										
	HYGIENE																	
30	Mother washed hands with soap during at least one critical activity yesterday	4	12	3	6	0	5	7	37	19	19	19	19	19	19	19	133	28%
		3	3	3	3	3	3	3										

SUMMARY TABLE CSP KIBILIZI= MOTHERS OF CHILDREN AGED 0-11 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	**Average Coverage=*Total Correct / Sample Size***
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
									MALARIA									
4	Heard of a mosquito net	18	19	18	19	16	19	18		19	19	19	19	19	19	19		
		NA	NA	NA	NA	NA	NA	NA	127								133	**95%**
5	Owns a mosquito net	11	11	10	7	5	10	6		19	19	19	19	19	19	19		
		7	7	7	7	7	7	7	60								133	**45%**
6	Child slept under net last night	8	7	10	6	5	6	4		19	19	19	19	19	19	19		
		4	4	4	4	4	4	4	46								133	**35%**
7	Child slept under TREATED net last night	9	8	6	7	5	7	3		19	19	19	19	19	19	19		
		4	4	4	4	4	4	4	45								133	**34%**
8	Mother slept under net last night	8	7	9	7	5	6	3		19	19	19	19	19	19	19		
		4	4	4	4	4	4	4	45								133	**34%**
9	Mother slept under TREATED net last night	6	7	6	7	5	6	3		19	19	19	19	19	19	19		
		3	3	3	3	3	3	3	40								133	**30%**
10	Child sick with fever in past two weeks	10	6	7	4	5	7	9		19	19	19	19	19	19	19		
		5	5	5	5	5	5	5	48								133	**36%**
12	Sick child with fever treated at health center	7	2	5	2	2	4	4		10	6	7	4	5	7	9		
		NA	NA	NA	NA	NA	NA	NA	26								48	**54%**

SUMMARY TABLE CSP KIBILIZI= MOTHERS OF CHILDREN AGED 0-11 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	**Average Coverage=*Total Correct / Sample Size***
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
13	Sick child with fever treated at health center within 24 hours of symptoms	3	0	3	0	0	2	1	9	10	6	7	4	5	7	9	48	**13%**
		NA	NA	NA	NA	NA	NA	NA										
	SOINS MATERNELS ET DU NOUVEAU-NE																	
14	Attended ANC during last pregnancy	18	19	18	18	17	17	19	126	19	19	19	19	19	19	19	133	**95%**
		16	16	16	16	16	16	16										
15	Attended at least 3 ANC visits last pregnancy	11	12	8	10	6	4	4	55	19	19	19	18	19	19	19	132	**42%**
		6	6	6	6	6	6	6										
16	Received at least 1 TT during last pregnancy	17	9	15	13	16	10	16	106	19	19	19	18	19	19	19	132	**80%**
		13	13	13	13	13	13	13										
17	Received 2 or more TT last pregnancy	17	13	15	11	14	4	16	90	19	19	19	18	19	19	19	132	**68%**
		11	11	11	11	11	11	11										
18	Has ANC card	12	14	6	16	12	13	5	78	19	19	19	19	19	19	19	133	**59%**
		9	9	9	9	9	9	9										
19	Completed 3+ ANC with TT 2 and has an ANC card	6	1	1	11	6	4	0	29	19	19	19	19	19	19	19	133	**22%**
		2	2	2	2	2	2	2										
20	Know at least 2 danger signs during pregnancy	9	12	4	18	8	12	16	79	19	19	19	19	19	19	19	133	**59%**
		9	9	9	9	9	9	9										

SUMMARY TABLE CSP KIBILIZI= MOTHERS OF CHILDREN AGED 0-11 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	Average Coverage=*Total Correct / Sample Size*
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
21	Know at least 2 danger signs for newborn	7	9	2	18	14	10	12	72	19	19	19	19	19	19	19	133	**54%**
		8	8	8	8	8	8	8										
22	Delivery assisted by TBA	7	5	7	5	7	3	6	40	19	19	19	19	19	19	19	133	**30%**
		3	3	3	3	3	3	3										
23	Delivery at Health Centre or Hospital (« Normal»)	3	9	2	6	4	4	9	37	19	17	19	19	19	19	19	131	**28%**
		3	2	3	3	3	3	3										
24	Delivery at Health Centre or Hospital (« with Complications reported»)	1	0	0	0	0	1	2	4	3	9	2	6	4	4	9	37	**11%**
		NA	NA	NA	NA	NA	NA	NA										
25	Post partum visit within one week of delivery	4	2	0	1	0	2	2	11	19	19	19	18	19	19	19	132	**8%**
		NA	NA	NA	NA	NA	NA	NA										
26	Child received newborn care within first week of birth	4	1	0	3	1	2	1	12	19	19	19	19	19	19	19	133	**9%**
		NA	NA	NA	NA	NA	NA	NA										
	VIH/SIDA																	
27	Heard of PMTCT	3	17	2	5	8	0	2	37	19	19	19	19	19	19	19	133	**28%**
		3	3	3	3	3	3	3										
28	Participated in PMTCT during last pregnancy	0	15	0	2	3	0	1	21	19	18	19	19	19	19	19	132	**16%**
		1	1	1	1	1	1	1										

SUMMARY TABLE CSP KIBILIZI= MOTHERS OF CHILDREN AGED 0-11 MONTHS

Health District:------KIBILIZI---/BUTARE---------- Date:…30 January 2004…

#	*Indicator*	*Total Correct by Zone / Decision Rule*							*TOTAL CORRECT*	*Sample Size by Zone*							*Total Sample Size*	**Average Coverage=*Total Correct / Sample Size***
		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		Gikore	Kansi	Kibayi	Kibilizi	Kigembe	Kirarambogo	Mugombwa		
29	Cord cut with new razor and tied with clean thread	17	19	19	19	18	18	19	129	18	19	19	19	19	19	19	132	**98%**
		NA	NA	NA	NA	NA	NA	NA										
	NUTRITION																	
30	Initiated immediate breastfeeding in first hour of birth	6	8	12	15	12	11	10	74	19	19	19	19	19	19	19	133	**56%**
		9	9	9	9	9	9	9										
31	Child breastfeeding	19	19	19	19	19	19	19	133	19	19	19	19	19	19	19	133	**100%**
		NA	NA	NA	NA	NA	NA	NA										
32	Children receiving foods and breastmilk *(aged 6 to 11 months)*	8	10	6	10	8	10	9	61	10	10	9	13	8	11	10	71	**86%**
		NA	NA	13	9	NA	NA	NA										
33	Child weaned by 6 months of age *(aged 6 to 11 months)*	6	7	1	10	5	2	2	33	10	10	9	13	8	11	10	71	**46%**
		NA	NA	NA	NA	NA	NA	NA										
34	Child received at least one food in each of the 3 food groups yesterday *(aged 6 to 11 months)*	1	2	2	2	3	5	4	19	10	10	9	13	8	11	10	71	**27%**
		NA	NA	NA	2	NA	NA	NA										